

**From Badness to Madness: Penal and Medical Knowledge in
Federal Women's Prison Policy**

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A Thesis in the Department of Sociology and Anthropology

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ABSTRACT

From Badness to Madness: Penal and Medical Knowledge in Federal Women's Prison Policy

Kristy Heeren

Canada's federal prison system, Correctional Service Canada (CSC), has made vast changes to the policies and structure of women's prisons over the past twenty years, claiming to have ushered in a 'new era' of "woman-centered," "culturally-sensitive," and "empowering" penology for women. Throughout this emergent policy development, the "psy-sciences" increasingly play a significant role, greatly influencing both the structure and operation of women's federal prisons and mental health services therein.

This research seeks to explore CSC's women's prisons by using an institutional ethnographic strategy, textual analysis, as defined by Dorothy Smith and others. The central analysis concerns the ways in which discourse and ideology inform institutional and medical 'knowledge', and subsequently structure women's federal prisons and mental health services therein, illuminating the ways in which institutional texts regulate and facilitate policy to serve the ideological goals of the institution.

The most salient and significant CSC policy texts published in the last twenty years were selected for analysis, and expressions of penal and medical "knowledges" were "mapped" to explicate the social and ruling relations that underlie CSC policy. Three primary rhetorical themes were identified in the texts: "Woman-centeredness/cultural sensitivity," "choice," and "correction/healing." These penal "knowledges" were examined and contrasted with CSC praxis. It is argued that CSC policy more accurately espouses neo-liberal ideology which reproduces sexism, racism, and the pathologization of women prisoners. It is concluded that CSC's purported achievement of a feminist and non-racist penal paradigm is more rhetorical than practical, as CSC continues to neglect social explanations for women's criminality and mental health status by individualizing women's problems and holding them personally responsible for their own criminal and mental "correction."

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I am also greatly indebted to Kim Pate, Director of the Canadian Association of Elizabeth Fry Societies. My discussions with her during the research process informed both my academic approach to the research, as well as my politics regarding prisons. Unbeknownst to her, these discussions played a significant role in determining my own philosophy about crime, incarceration, and prison abolition, inspiring in me what I foresee to be a life-long commitment to social justice for women in conflict with the law.

Finally, with deep sadness I must acknowledge those women—past, present and future—behind bars in Canada. The struggles that they face lie directly at the heart of much that is wrong with our society. The experience of women in conflict with the law, both before and after their criminalization, is the real breach of justice.

My heart goes out to you, your family, your friends, your communities.

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List of Acronyms

CAEFS – Canadian Association of Elizabeth Fry Societies
CCRA – Corrections and Conditional Release Act
CCRR – Corrections and Conditional Release Regulations
CHRC – Canadian Human Right Commission
CSC – Correctional Service of Canada
DAWN – DisAbled Women’s Action Network
DBT – Dialectical Behavioural Therapy
ERT – Emergency Response Team
FAE – Fetal Alcohol Effects
FAS – Fetal Alcohol Syndrome
FASD – Fetal Alcohol Spectrum Disorder
IIS – Intensive Intervention Strategy
IHP – Intensive Healing Program
NIWG - National Implementation Working Group
OOHL – Okimaw Ohci Healing Lodge
P4W – Prison for Women, (Kingston, Ontario)
PSR – Psychosocial Rehabilitation
SE – Secure Environment
SLE – Structured Living Environment
TFFSW – Task Force on Federally Sentenced Women

Chapter One: Introduction

On October 19th, 2007, a 19-year-old woman incarcerated in a federal women's prison in Kitchener attempted to commit suicide in her jail cell. Ashley Smith asphyxiated herself in plain view of prison guards who watched through a video camera and neglected to intervene in her suicide attempt. She later died in a hospital. Smith was being incarcerated in Ontario, hundreds of miles away from her friends and family in her hometown, Moncton, New Brunswick (Huber, 2007). Despite her age, Smith had spent a large part of her sentence in segregation, and carried more than 700 incidents on her file since her incarceration at the age of fifteen. Smith's death is only the most recent suicide of federally sentenced women. Since 1988, at least 12 federally sentenced women have committed suicide while incarcerated in Canada—three of those have occurred since 2000 (CAEFS, 2004).

Media attention on this most recent tragedy has put the spotlight on Correctional Service Canada's (CSC) treatment of prisoners with mental health problems. The CSC has responded to this attention by stating that it is struggling to cope with the increasing number of inmates entering prisons with mental illness¹ (Huber, 2007). Recently the CSC has released staggering statistics regarding the mental health of newly admitted prisoners. Twenty-five percent of women inmates are diagnosed with mental illness upon their admission into federal prisons (CSC, 2007a: 4); this rate is a 100 percent increase from just ten years ago (Huber, 2007). According to CSC commissioner Keith Coulter, a lack of resources and "gaps in community-based mental health services" (CSC, 2007a: 4) has

¹ The CSC has also responded to this incident by dismissing three guards and a supervisor, all of whom have been charged with criminal negligence causing death (Huber, 2007).

resulted in a strain on mental health services in federal prisons (Huber, 2007). Although Coulter's explanation may partially answer how Smith was failed by mental health services in prison, it absolves CSC for its responsibility in the neglect and mismanagement of prisoners. It also fails to explain a host of questions that such an incident provokes: Why are increasing numbers of women in prison being diagnosed with a mental illness? How does the CSC diagnose and treat women's mental health? Are federal prisons alleviating or exacerbating women's mental problems? And more poignantly, in light of incidents such as Smith's suicide, is Correctional Service Canada achieving its mandate to 'correct'?

Ashley Smith's death is just the most recent example of the CSC's turbulent history with female federal inmates. There have been numerous Task Forces, Commissions, and Reports about ongoing, systemic abuses and discrimination against women prisoners, many of these since the mid-1990s (Arbour, 1996; CAEFS, 2005; CHRC, 2003; Laishes, 2002; Peters, 2003; TFFSW, 1990). As recently as 2003, the Canadian Human Rights Commission released a report condemning federal corrections services for their treatment of Aboriginal women and women with mental and cognitive disabilities. This report follows a long history of criticism of the CSC's treatment of female inmates accusing CSC of failing to address the particular needs of Canada's federally sentenced women.

CSC's Women's Prisons: A Brief History

Correctional Service of Canada is the branch of the federal government's criminal justice system responsible for the incarceration and 'correction' of Canada's convicted offenders who have received a sentence of two years or more. The CSC is composed

primarily of men's prisons, while women's prisons occupy a marginal place within the entire organization. For every women's prison, there are eight prisons for men. While there are around 18 000 people in federal incarceration any given time, there are usually no more than 400 women inmates (CSC, 2006: 12), around 2% of the entire inmate population. Women prisoners constitute a very small but very diverse population.

Until 2000, the CSC had housed all female inmates in the maximum-security Prison For Women (P4W) in Kingston, Ontario (Hannah-Moffat & Shaw, 2000). Various Task Forces and Commissions had revealed the appalling conditions of P4W since its establishment in 1934. It was eventually shut down following Madame Justice Louise Arbour's (1996) investigation into the abuse of women prisoners during a prison riot in 1994 in which several female inmates were strip-searched by male guards in riot gear and transferred into segregation cells connected to a male sex-offender unit (Balfour, 2006: 737). Arbour's investigation exposed these events—amongst other decades-long human rights violations—galvanizing the closure of the P4W in 2000. It was replaced with five small regional women's facilities across Canada, and a “healing lodge” in Saskatchewan for Aboriginal women.

In the past 15 years, the CSC has drastically transformed women's incarceration through such modifications as the closure of the P4W, the opening of regional facilities, the development of the Okimaw Ohci Healing Lodge, and the transformation of programming and principles that CSC claims reflect a new era in “women-centered” and “empowering” penology. While the CSC offers these changes as evidence that the era of human rights abuses, negligence, and discrimination in women's prisons are through, Ashley Smith is an unfortunate indication to the contrary. Her death illustrates the urgent

need for critical research on women's federal prisons and mental health programming therein, which seeks to identify, and indeed challenge, conventional institutional wisdom. This research contributes to an emergent body of feminist criminological literature, which aims to unearth the underlying power relations of Canada's federal women's prison policy, and provide alternative "knowledges" to those produced by the CSC.

Research Objectives

The continual restructuring of Canada's federal prison system, most notably in the past fifteen years, has included vast modifications to the physical and mental health strategies for female prisoners. However, there continues to be severe gaps in the understanding of this population. Increasingly, sociologists, criminologists and CSC staff have called for greater research on women's prisons, as well as prison health services specifically (Hannah-Moffat, 2001; Hannah-Moffat & Shaw, 2000; Laishes, 2002; Micucci & Monster, 2004; Pollack, 2000a). This emergent body of work identifies several deficits in mainstream criminological research on women prisoners and health services:

- a) First, there is a marked absence of sufficient research on this subject. To date, little primary data has been collected on women's health conditions and health needs in prisons in Canada. The literature repeatedly calls for more research in this field, specifically primary and qualitative research (Laishes, 2002; Micucci & Monster, 2004).
- b) Second, there is a general consensus that female prisoners themselves must participate in the evaluation of health services and treatments (Hannah-Moffat, 2001; Hannah-Moffat & Shaw, 2000; Pollack, 2000b), rather than health care professionals and corrections staff alone. Indeed, according to the Canadian Human Rights Commission,

one of the primary health problems women face in prison is their health needs being ignored (2003: 35).

c) Women's experiences of physical and mental health must be understood as gendered. Female prisoners possess alarmingly high levels of past experiences of poverty, abuse and victimization, which, many argue, contribute to their criminality (CAEFS, 2005; CHRC, 2003; Kendall, 2002; Laishes, 2002; Peters, 2003). The 2003 Canadian Human Rights Commission (CHRC) investigation of female federal inmates argues that this population, especially Aboriginal women, is more likely to have “more sickness, more disability and more psychological distress” than male prisoners (CHRC, 2003: 35). They are also much more likely to be diagnosed as mentally ill (including depression, schizophrenia, or post-traumatic stress disorder), have a substance abuse problem or sexually transmitted disease, and have past suicidal or self-injurious behaviour, than the male prison populations or the Canadian population at large (CHRC, 2003; Laishes, 2002; Micucci & Monster, 2004).

Men and women have different experiences which impact their path to criminal activity, as well as their experiences in prison (*ibid.*). The sociological context of women's experiences outside and inside prison are “both quantitatively and qualitatively different from those of men” and should therefore be considered independently (Hannah-Moffat and Shaw, 2000: 20). Such research lends evidence to the claim that women's social status and health, especially mental health, play a significant role in their criminalization. Therefore, researchers have suggested that research conducted on this population must acknowledge female prisoners' specific experiences of poverty and

victimization, and how this contributes to special psychological health needs (Acoca, 1998; CHRC, 2003; Kendall, 2002; Laishes, 2002; Pollack, 2000b).

d) Finally, research suggests that women have been all too often neglected when addressing health issues of prisoners (Hannah-Moffat, 2001; Hannah-Moffat & Shaw, 2000, 2001; Laishes, 2002; Micucci & Monster, 2004; Pollack, 2000b). Not only have male health concerns been the norm for creating policy for women's prisons, little research has been conducted to assess the application of women's prison health policies. There exists a need for additional research on mental health policy in Canada's federal women's prison system, and on institutional practices in women's prisons more generally.

This thesis begins with some of the gaps in research on women's federal prisons, and the health services therein. In light of the vast modifications to CSC's women's prisons recently, this thesis investigates this 'new era' of CSC's women's prison policy. Few sectors of women's prisons remain unchanged, and mental health services are no exception. The restructuring of women's federal prisons has greatly affected the ways in which mental health services are provided, and with the ever-increasing rate of women in prison labeled with some form of mental illness, critical research on this subject is beyond necessary—it is urgent. The contexts in which women come into conflict with the law, the specific histories of racism, poverty and violence that many incarcerated women have endured, and the mental health needs of incarcerated women all intersect. The resultant context constitutes a complex nexus of power relations as so many federally sentenced women are institutionalized as both prisoner and patient.

My thesis will begin with the principal governing texts of the institution in order to map the 'social relations' of federal women's prisons in Canada. By analyzing the governing texts of women's prisons, I will explore the institutional policies, ideologies and discourses which shape the organization of prison and the provision of health services therein. This research seeks to assess women's prison and health service policy, to understand how prison and health services are shaped by institutional documents. The role that texts play in generating institutional and medical 'facts,' and how such 'knowledge' impacts prison and health policy, is the primary focus of the investigation. It will also provide an exegesis of the power relations inherent in the CSC's penal and medical 'knowledge' and illustrate the ways in which such power relations are both invisible and ideological. A feminist perspective will be used to analyze the data, and to understand the production and application of institutional ideologies which both implicitly and explicitly structure the organization of CSC's women's prisons.

This research seeks to explore Correctional Service of Canada's women's prisons by using an institutional ethnographic approach. The ways in which ideologies inform institutional and medical 'knowledge', which then subsequently inform the structure of women's federal prisons and the provision of its mental health services, is the central interest of this work. In order to investigate the CSC's policies for women's health programming, I will employ the first methodological stage of Institutional Ethnography, Textual Analysis, as defined by Dorothy Smith (2005, 2006a) and others (Campbell, 2003; Campbell & Gregor, 2004; Turner, 2006).² A textual analysis of the institutional texts and policy documents of the CSC and its mental health services will illuminate the

² Performing a complete Institutional Ethnography of women's federal prisons is far beyond the scope of a Master's thesis. A comprehensive Institutional Ethnography of federal women's prisons would be better completed as a Ph.D. Dissertation.

ways in which policy structures and facilitates women's prisons to serve the ideological goals of the institution.

Chapter two, the literature review, introduces the theoretical backgrounds used to structure the thesis—Institutional Ethnography, Feminist Criminology, and the Sociology of Medicine—and explores relevant research on institutional power, women's incarceration, and sociological theories of 'mental health.' While each theoretical discipline provides its own unique tools with which to analyze CSC's women's prison policy, they also overlap and compliment each other. Dorothy Smith used concepts within Institutional Ethnography to analyze the ideological power of psychiatry through a feminist lens (D. Smith, 1975, 1990a, 1990b; D. Smith, 2006a). Some feminist criminologists have devoted much of their academic career researching Canadian women's prisons (Balfour, 2000, 2006; Faith, 1993, 1995; Hannah-Moffat, 1999, 2000, 2001, 2004a, 2004b; Hannah-Moffat & Shaw, 2000, 2001; Hayman, 2006; Kendall, 2000, 2002; Micucci & Monster, 2004, 2005; Monture-Angus, 2000, 2002; Pollack, 2000b), while some have specifically critiqued the application of the "psy-sciences" in women's prisons (Balfour, 2000; Kendall, 2000; Pollack, 2000a). While institutional ethnography is relevant to analyses of institutions of any kind—including prisons—neither Smith nor other institutional ethnographers have applied the methodology to Correctional Service of Canada's women's prisons exclusively to date. Chapter two will explore how all three theoretical tools illuminate both an Institutional Ethnography of mental health services in Canada's women's federal prisons.

Chapter three, the Methods, begins with the theoretical foundation of Institutional Ethnography—and textual analysis specifically—as a methodology, and explains how it

can be applied to a correctional institution. This is followed by a discussion of the theoretical questions used to guide the thesis, and how these are structured by an institutional ethnographic approach. This work draws upon feminist criminology and the sociology of medicine to explore the policies and principles that are used to organize mental health programming in women's federal prisons. The research design is described, detailing the body of data used as the 'corpus' for analysis. The chapter lays out the institutional structure of Correctional Service Canada's primary governing policies and principles, and how these texts establish the foundation through which CSC's women's prisons may be "mapped" (D. Smith, 2005). These texts serve a significant role in determining "how things happen" (Campbell, 2003: 3) in women's prisons, and they objectify the ideological, paradigmatic and discursive foundations of CSC's policies. Three levels of data are identified: Governing texts of the CSC more broadly; women's prison policy; and mental health policy therein. Finally, the chapter explores how these data were analyzed, using concepts and queries drawn from feminist criminology and the sociology of medicine.

Chapter four reports the research findings and focuses primarily on the structure, or 'map,' of CSC's mental health services in women's prisons. It begins by mapping the institutional practices of CSC at the broadest level, then places women's correctional facilities into this context. Women's mental health services are then discussed and mapped into the broader contexts of women's prison policy more generally as well as CSC's institutional structure at large. This chapter is primarily devoted to piecing together the organization of women's prisons and mental health policy therein to query "how things happen" (ibid.) inside women's prisons. The findings describe how the data

were “read selectively” and analyzed in order “find the sense it can make in particular settings of action” (D. Smith, 2006a: 68).

Chapter five discusses the ideologies, paradigms and discourses used in CSC’s prison policy, seeking to answer the research questions guided by the theoretical paradigms employed in the research process. Three primary ideologies and discourses were discovered, and each of these were contrasted with the discourses and rhetoric employed within CSC policy. First, CSC’s rhetorical use of “Women-centeredness” and “Cultural Sensitivity” within women’s prison policy is contrasted with ‘Decontextualizing’ discourses inherent in CSC’s praxis. While CSC argues that its ‘new era’ of correctional policy is both pro-feminist and anti-racist, I argue that the CSC continues to decontextualize the social contexts from which many incarcerated women come, and in so doing, maintains sexist and racist ideologies throughout CSC prison policy. Secondly, the use of a “Choice” rhetoric within CSC policy is contrasted with ideologies of ‘Individualization’ and ‘Responsibilization.’ It is argued that while CSC’s policies claim to increasingly offer women prisoners more ‘choice’ and control in their ‘correctional’ experience, the CSC in fact employs the discourse in specifically paradigmatic ways in order to hold women prisoners individually responsible for their circumstances. Instead of being given more meaningful ‘choices,’ women prisoners are responsibilized for their role in criminal activity, their mental health, and their subsequent carceral experience. Finally, I contrast CSC’s use of “Correction” and “Healing” rhetoric with ‘Medicalization’ and ‘Pathologization’ discourses within its policies, arguing that instead of providing an environment where women prisoners are “healed,” the CSC medicalizes and pathologizes women prisoners by applying psychiatric regimes and

treatments to them. Further, I argue that such practices maintain the decontextualization and responsabilization of women prisoners while denying the role of sexism, racism and classism in women's criminalization and mental health problems.

The thesis concludes with a discussion of the implications of CSC's women's prison policy and mental health services in chapter six. I argue that while such "empowering" language throughout CSC policy may serve a rhetorical value, in practice, CSC continues to marginalize women, particularly Aboriginal women, while maintaining the very social forces that contribute to women's criminalization and mental ill-health: sexism, racism and classism. Finally, I discuss alternative systems of criminal justice and mental health programming. It is argued that, ultimately, seemingly 'feminist' reforms in prison policy do little to ameliorate the marginalization of women behind bars, and that "healing" and "correction" are not even possible in carceral environments. If the criminal justice system seeks to "correct" and "heal" women in Canadian federal prisons, attention must be redirected towards the social inequalities that women face in Canadian society.

Chapter Two: Theoretical Background: A Literature Review

My exploration of the nexus of social relations that facilitate women's criminalization and subsequent governance through federal women's prison policy is informed primarily by three theoretical approaches: feminist criminology; the sociology of medicine; and Institutional Ethnography. I draw upon these theoretical frames—elaborated below—to identify relevant information about the institution's organization, 'knowledges,' and ideological positions. Feminist criminology informs my theoretical framework at the most general level. This approach is useful for understanding the role that oppression plays in women's criminalization, both in their path to criminalized activity, as well as their treatment in prison thereafter. It also helps to plot a map of social, institutional, and discursive processes that shape women's relationship to the law. As we will see, these criticisms can be closely interrelated with sociological critiques of medicalization. Historically, medicalization and criminalization have operated as complimentary social processes, both seeking to impose 'correction' onto a deviant subject, who may or may not be institutionalized. Together, medicine and incarceration compose the most effective, and most inconspicuous, methods of social control. Their 'facts' and 'knowledge' tend to be assumed by institutions and the professionals therein, as well as the population at large. Therefore, the ways in which penal and medical knowledges operate in tandem are a significant sociological issue. Institutional ethnographic theory exposes these very ruling relations behind institutional practices and reveals the way in which institutional 'knowledge' assumes its own ideology as 'fact,' and in so doing, subordinates other ways of knowing and interpreting the world.

Prison health services have historically been accused of providing inadequate medical care for incarcerated women and applying androcentric health policy to women in general, which, it is argued, is detrimental to their health status. Consequently, the most common health-related argument made about incarcerated women (see Ferraro and Moe, 2003; Zaitzow, 2003; Abramsky and Fellner, 2003) has been that they are *under-medicalized* and require increased medical attention, and that, by extension, prison policy should be reformed to provide this service. More recently, however, there has been an emergence of work which critiques the biomedical paradigm employed within prisons and penal ideology more broadly. This perspective examines the *social construction* of health and the role of medicalization in the social control of populations. The central concern of this perspective does not centralize the health ‘needs’ of women prisoners, but examines the ways in which medical knowledge is applied to prisoners in a coercive or disciplinary manner, resulting in their *over-medicalization* or ‘pathologization.’ It has been argued by those who have employed sociological critiques of medicine that such processes reflect methods of social control and subjugation, whereby prisoners’ minds and bodies become the location of punishment and ‘correction’ (Faith, 1993: 48; Kendall, 2000; Timmermans and Gabe, 2002; Peters, 2003; Girshick, 2003; Davis, 2003: 66). Rather than investigating the mental health status and assumed health needs of women prisoners according to a western bio-medical or psychiatric paradigm, this perspective explores medicalization as a social process, one that reflects ideological agendas, and through them, shapes the organization and policies of prisons.

While each theoretical perspective composes its own body of literature, they also overlap with one another. The sociology of medicine provides insight into the social

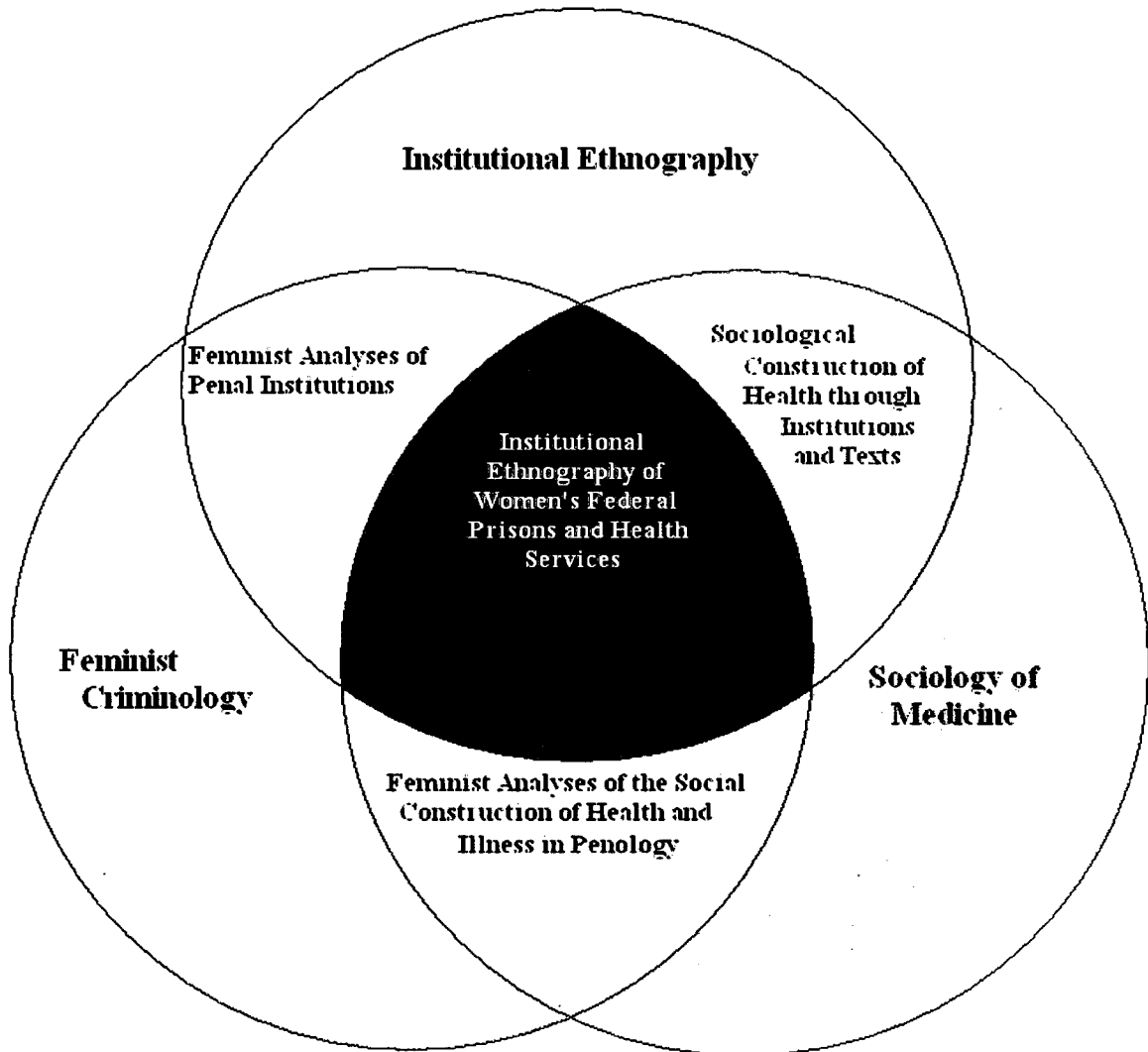
construction of mental health more broadly, while feminist and criminological theories have been used to inform research about health issues within penology. Within feminist criminology, some research has highlighted health issues of women in conflict with the law, while some has focused on an analysis of health services in penal institutions, and some both. Institutional Ethnography, meanwhile, has been developed using both an explicit feminist perspective and was inspired by sociological critiques of modern psychiatric medicine. Figure 1.0 (page 15) illustrates the theoretical backgrounds employed in this research, and the areas in which they overlap, locating this research at the centre.

Feminist Criminology

The connection between social marginalization, poverty, and criminalization has been well established in sociology. Historically, social policy on crime has focused on and targeted lower socio-economic groups (Carlen, 1988: 6) and prison populations have been disproportionately constituted by the poor and socially disadvantaged (Carlen, 1988; Foucault, 1995). During the 1980's, poverty became more comprehensively criminalized in both Canada and the U.S., where mostly poor people of colour were selectively criminalized by neo-conservative programs such as the 'War on Drugs' (Faith, 1993: 92; Logan, 2004: 261). Shifts in socio-economics and criminal justice trends resulted in some women becoming more vulnerable to poverty and criminalization. The "feminization of poverty" (Pearce, 1978) was first identified in the late 1970s, while the number of incarcerated women climbed rapidly.

By the early 1990s, women who were the primary source of support for either themselves or their families increasingly constituted those living in poverty (Goldberg &

Figure 1
Theoretical Backgrounds of Research



Kremen, 1990). This process was also considered evidence of the “feminization of poverty,” which referred both to the growing rate of self-supporting women living below the poverty line, as well as the number of women who *would* be living in poverty if they had to become self-supporting (Goldberg & Kremen, 1990: 2). Children are therefore also greatly impacted by this trend, since they compose the majority of the population of

individuals living in female-headed households (Mahowald, 1993: 219; Goldberg & Kremen, 1990). Pearce first identified the “feminization of poverty” in 1978, and the concept garnered much attention from feminists and academics throughout the 1980s. A number of causes have been cited for women’s increasing vulnerability to poverty including the loss of primary income support from men (through divorce or death of a spouse); lack of child support from men; inadequate benefits from social assistance programs; employment segregation and discrimination faced by women; and finally, that much of women’s labour earns either little or no income at all (Goldberg & Kremen, 1990; Mahowald, 1993). All of these factors indicate a variety of ways in which women may come to face socio-economic marginalization.

Research on women’s crime has illuminated the links between women’s economic marginalization and their criminalization. Steffensmeier and Allan’s comprehensive review of criminological research on crime and gender shows that there are key differences in the ways women enter into criminal activity when compared to men. Specifically, women’s exclusion from more lucrative crimes, consequences of motherhood, their vulnerability to exploitative men on the street, prostitution as a lucrative income, and the involvement in crime through men in their lives, to name but a few, are all situations that arise as a result of women’s economic marginalization, whereby economic dependence on men becomes a solution or opportunity that is later criminalized (Steffensmeier & Allan, 2004: 111). Women’s crime also frequently involves property offenses and drug dependency, both of which are associated with economic hardships (Steffensmeier & Allan, 2004: 107).

In the past 30 years, the erosion of the welfare state, and cuts to welfare specifically, have had a direct impact on incarceration levels (Beckett & Western, 2001: 43). Since the 1980s, the rate at which women have been sentenced to prison has risen dramatically, while the same cannot be said for men (McIvor, 2007: 10). When neo-liberal government policies reduce welfare protections and social services—such as social housing or daycare—and simultaneously expand economic criminal categories, women become particularly vulnerable to criminalization (Balfour, 2006: 740). The Canadian Association of Elizabeth Fry Societies (CAEFS), which conducts research and advocates on behalf of criminalized women and girls, points out that cuts to welfare impact women the greatest because of their economic marginality, and drive them towards criminal activity,

Cuts to welfare...ha[ve] resulted in the provinces and territories being able to cut social services to the point that those who have historically been most marginalized are increasingly at risk...There are no provinces where welfare rates are actually adequate to support the poor. In order to survive, most people, especially poor mothers, who are the sole supporters of their families, are required to obtain income by means that would be considered fraudulent if welfare authorities became aware of it. (CAEFS, 2005: 12)

Beyond economic marginalization, women are additionally vulnerable to subjugation by family members, domestic partners, and authorities, which may lead to criminalization. Chesney-Lind and Pasko (2004) have shown that women and girls often employ survival strategies in the face of violence, such as running away, often ending up on the street or living in dilapidated conditions. These situations lead many women to acts such as panhandling, theft, and sex work, all of which may result in trouble with the law. In effect, women in conflict with abusive parents, family members, or partners are forced

into breaking the law to survive (ibid.). Such research illustrates that women's economic inequality plays a critical role in their criminalization.

Along with the feminization and criminalization of poverty, so too have mental disorders been criminalized (CAEFS, 2005; Peters, 2003). Not only has it been shown that incarceration serves to offset high unemployment rates (Timmermans & Gabe, 2002: 504), but also that incarceration has become an accepted alternative to psychiatric institutionalization (Peters, 2003; CAEFS, 2005). The movement to "de-institutionalize" those diagnosed with mental illness has resulted in greater numbers of the unemployed who could or would be dependent on the state for support. This has disproportionately impacted women, who have traditionally been over-represented in mental institutions (Peters, 2003: 5).

Cuts to social services have resulted in the closure of many psychiatric institutions, leaving those with mental health problems to be cared for by community-based facilities (for those who can afford it), or medication. However, many people end up in Emergency rooms, on the streets, and subsequently in prison (Peters, 2003; Timmermans & Gabe, 2002: 512). Yvonne Peters' report, *Federally Sentenced Women with Mental Disabilities: A Dark Corner in Canadian Human Rights*, provides a human rights analysis of CSC's treatment of federally sentenced women with mental disabilities. Peters asserts,

In many cases, society responds to the attempts of [the mentally ill] to survive with inadequate resources by characterizing their behaviour as criminal, labeling them as criminal 'offenders', and institutionalizing them in the criminal justice system. Social and economic challenges such as homelessness, unemployment, social isolation, malnutrition, and substance abuse further compound the plight of persons with mental disabilities to survive in the community (2003: 5).

Canada's penal system has seen a marked increase in the number of women with mental and cognitive problems being incarcerated (CHRC, 2003; CSC, 2006: 13, 2007a: 4; Peters, 2003). Incarcerated women have had significantly higher rates of mental illness diagnoses throughout their lives than both male prisoners or the general female population, including schizophrenia, depression, substance abuse disorders, and anti-social personality disorders (Laishes, 2002). Both the Canadian Human Rights Commission's and the DisAbled Women's Action Network's inquests into discrimination and human rights abuses in federal women's prisons independently concluded that the higher incidences of mental health problems of women in prison are largely connected to their demographics of economic and social subjugation, and past experiences of early and/or ongoing sexual and physical abuse or assault (CHRC, 2003; Peters, 2003: 7). Particularly alarming are the rates of social and economic subjugation of Aboriginal women in prison, including their rates of past experiences of abuse and violence, as well as their rate of incarceration.

Aboriginal women constitute 1-2% of Canada's population, but over 30% of federal women inmates (CAEFS, 2005: 15; CSC, 2006: 12). Ninety and 60% of federally sentenced Aboriginal women report physical and sexual abuse respectively throughout their lives (Peters, 2003: 5). The mental distress of abuse is compounded by third-world levels of poverty found in many Aboriginal communities in Canada, and the historical effects of assimilation and cultural genocide against Aboriginal peoples throughout Canada and the Americas. Some feminist researchers have described the feminization of poverty, the criminalization of women, and systemic racism in the criminal justice system as a "victimization-criminalization continuum" (Balfour, 2000; Faith, 1993). Canada's

federally sentenced female population is disproportionately poor, disproportionately Aboriginal, and report extremely high rates of past abuse and mental illness diagnoses (Balfour, 2000; Faith, 1993). These characteristics support the hypothesis that oppression plays a large role in both women's criminalization as well as mental distress which could impact their likelihood of receiving a mental illness diagnosis.

In light of such demographics, it is often agreed by those researching women's incarceration that it is inappropriate to place many imprisoned women in 'correctional' institutions, and that better psychiatric care may be a more effective and appropriate response to women's criminality. However, such an assumption fails to ask how psychiatric attention itself may be inappropriate if it likewise fails to recognize the social contexts within which many women commit crime. The 'reality' and legitimacy of women's mental illness often goes unchallenged in research on incarcerated women in order to stress the toll that violence, and economic and social marginalization take on women's mental health, and that 'different' or 'better' mental health services for women (such as more long-term therapy) are in dire need (for examples, see Abramsky & Fellner, 2003; Ferarro & Moe, 2003). The CSC has greatly reorganized women's prisons, including mental health services, in response to calls for reform; however, my research challenges the assumption that such reforms have improved the "correctional," "rehabilitative" or "therapeutic" value of incarceration for women. While my research does not contest the assertion that the past histories of poverty, racism and violence of many incarcerated women largely contribute to specific and significant mental health needs, I investigate how such calls fail to question how reformed psychiatric services

may also neglect to address the socio-political context of women's lives, and furthermore, may serve a disciplinary function which contributes to women's oppression.

Feminist Criticisms of Correctional Service of Canada

CSC has made significant reforms to women's prisons over the past 15 years, predominantly through the restructuring of women's correction policy and the closure of the P4W. Following numerous reports criticizing CSC's women's prisons, most notably the Task Force on Federally Sentenced Women's report *Creating Choices* in 1990, CSC claims to have reformed women's prisons by developing "woman-centered" penology and adopting "gender-sensitive" principles into women's federal prison policy, as recommended by the report. Additionally, CSC has responded to claims of systemic racism by developing a "healing lodge" and "Aboriginal programming." While some feminists may be asking challenging questions about the treatment of women in prison facilities and demanding feminist prison reforms, others are challenging the very ideological practice of incarceration in Canada. Many have contested the CSC's claims that the new "woman-centered" programming and policies increasingly offer incarcerated women more "choices" (CAEFS, 2002, 2005; Kendall, 2000, Hannah-Moffat, 2004a). Rather than offering women more significant and meaningful choices, they argue that the criminal justice system individualizes women's criminal activity by decontextualizing the socio-politico-economic realities in which women commit crime.

Criminologists have also argued that there has been a neo-liberal shift in penal regimes from punitive to 'correctional,' whereby prisoners are increasingly held personally responsible, or 'responsibilized' (Garland, 1997: 191; Hannah-Moffat, 2000), for their criminal activity as well as for their own rehabilitation. Criminals are no longer

simply condemned for their actions (warranting mere punishment as an appropriate consequence), but are held responsible for their own fate (warranting 'correction' as the appropriate consequence) (Timmermans & Gabe, 2002: 505). Criminology Professor Hannah-Moffat, whose academic career has largely been devoted to researching federally women's prisons, argues that CSC's new "women-centered empowerment model" of corrections may not be challenged by prison-reform advocates, despite that women prisoners are no more in control of the social and systemic inequalities from which they came, and to which they will return upon release (2000: 32). She states that the CSC's definition of "empowerment" is more closely connected to the individual prisoner's ability to take responsibility for her 'criminality' and 'rehabilitation,' whereas most feminists identify 'empowerment' as changes to structural power relations beyond the control or responsibility of the prisoner herself (2000: 34). Women prisoners are therefore 'responsibilized' for both their crime and correction, "irrespective of structural or situational forces in their lives" (Hannah-Moffat, 2000: 33). The Canadian Association of Elizabeth Fry Societies (CAEFS) has further criticized the responsibilization of prisoners, arguing that people cannot reasonably be held responsible for a crime if the alternative is absolute poverty, homelessness, death, or any form of harm to the individual (2005: 8).

Others have argued this decontextualization-individualization-responsibilization process is also evident when it comes to the medicalization of prisoners. With the historical penological shift from punishment to 'correction,' prison discourse now 'responsibilizes' the individual to take responsibility and achieve her or his own 'rehabilitation' (Foucault, 1995; Garland, 1997; Timmermans & Gabe, 2002). In so

doing, social explanations of individuals' psychological troubles are ignored and decontextualized, and the responsibility for crime and ill health are placed solely on the person herself (Faith, 1993: 175; Haney, 2004: 345; Pollack, 2000b: 72). It has been argued that this individualizes women's 'pathologies,' denying sociological explanations for mental health problems, and holding them personally responsible for their troubles as well as their 'healing' (Kendall, 2000; Correctional-Investigator, 2004; CAEFS, 2005).

Some feminist criminologists have argued that women's criminality is decontextualized in multiple ways. First, the social conditions and inequalities that lead women to commit crimes in the first place are ignored when they are processed through the justice system (Faith, 1993: 175; CAEFS, 2000, 2005; Steffensmeier & Allan, 2004: 106)—criminal processes interrogate the criminalized person rather than the social forces that explain their crime (Faith, 1993: 175). Moreover, women prisoners are held individually responsible for the success of their own correction and rehabilitation rather than the CSC's programming itself (Pollack, 2000b: 73). Secondly, once in prison, behaviours and needs that are responses to past histories of distress are framed as risky or criminogenic once incarcerated (Hannah-Moffat, 1999; Monture-Angus, 2002: 17). Kelly Hannah-Moffat has illustrated in numerous studies (1999, 2000, 2001, 2004b; Hannah-Moffat & Shaw, 2001) on CSC's Risk Assessment policy that parole boards attribute "risk" to women with past histories of abuse, and often conflate mental health "needs" with criminogenic "risks." For example, self-harm (such as "cutting") is a common response for women with histories of abuse and violence, and many women in federal prison engage in self-harm (Peters, 2003: 7). Women who self-injure because of past experiences of abuse are more likely to be considered "at risk" of violent re-offence in

the future, thus locking them into longer sentences and greater restrictions while incarcerated (Hannah-Moffat, 1999). Thirdly, it has been argued that mental health services decontextualize women's social circumstances by "translat[ing] social disadvantage into pathologies" (Correctional-Investigator, 2004: n.p.) in their classification systems, particularly in the cases of Aboriginal women in Canadian federal prisons (Kendall, 2000: 91; CAEFS, 2002: n.p., 2005: 14; Peters, 2003: 6). Women with greater mental health needs tend to be characterized by CSC as 'unmanageable' rather than mentally-distressed, are thus more likely to be classified in Maximum Security resulting in greater restrictions to their freedom (CAEFS, 2002, 2005; Peters, 2003). Such decontextualizing penal processes, according to Shoshana Pollock, are characterized by neo-liberal ideology which assumes that "'good' choices are equally available to all people" (Pollack, 2000b: 73) regardless of gender, race, class or personal history. These accusations indicate that CSC largely holds women prisoners personally responsible for both their criminality as well as their successful 'correction' through incarceration. Even more alarming, this research indicates that women prisoners are both blamed as well as punished for the consequences of their past personal histories and socio-economic contexts that arise from social inequalities beyond their control.

In 1990, CSC published *Creating Choices* (TFFSW), heralded as a seminal text in their move towards "women-centered" reforms. Since then, Canadian feminist criminologists and sociologists have been critiquing the CSC's claim that meaningful and responsible choices can be provided to incarcerated women. This emergent "opportunities model" of penal philosophy assumes that rehabilitation cannot be enforced by the prison but only "chosen" by prisoners themselves (Kendall, 2000: 88). The

Canadian Association of Elizabeth Fry Societies, which works directly with federally incarcerated women, and criminologist Kelly Hannah-Moffat argue, however, that such meaningful choices are not even available in prisons, and implementing “woman-centered” principles is not possible in a prison setting (CAEFS, 2002; Hannah-Moffat, 2004a). In particular, Hannah-Moffat, an expert in Canadian federal women’s prisons whose data come from over 500 case files, argues that:

Non-existent opportunities and choices make it almost impossible for women to make what they regard as “meaningful choices.” Women in prison lack the power and autonomy to make even the most mundane decisions and choices such as when to get up and go to sleep, when and what to eat, when and whom to visit. (2004a: 301)

The assertion that incarcerated women suffer from a lack of meaningful “choices” has also been applied to broader aspects of CSC’s women’s-prisons beyond the “mundane decisions” (ibid.) over which imprisoned women have no control. Sociology professor Kathleen Kendall, who was employed by CSC to evaluate women’s programming in the 1990s and has since greatly critiqued the CSC in her academic work, has shown that women lack meaningful choices in any prison programming, including mental health services. She has illustrated that women inmates need a choice whether or not to participate in mental health programming (Kendall, 2000, 2002). However, Stephanie Hayman’s recent comprehensive analysis of CSC’s new women’s prisons illustrates that the therapeutic environment within CSC does not encourage any such personal choices (Hayman, 2006: 95).

Many feminist researchers have argued that the power relation between the incarcerated person and the institution is inherently contrary to a therapeutic, supportive and empowering environment. They argue that the prison system is antithetical to

empowerment as it is first and foremost a punitive system that exists to hold persons accountable for their actions through unequal power relations between prisoners and the institution (Hannah-Moffat, 2004a: 307; Kendall, 2002: 82; Peters, 2003: 5). Several reports on CSC's treatment of women inmates that collected data from federally sentenced women directly have shown that women are stripped of any agency to make choices concerning their rehabilitation because they are actually coerced into participating in programming or involuntarily placed into psychiatric facilities (CAEFS, 2002: n.p., 2005: 13; Correctional-Investigator, 2004: n.p.; Peters, 2003: 17). The Canadian Association of Elizabeth Fry Societies (2005), The DisAbled Women's Action Network (DAWN) of Canada (Peters, 2003), and the Federal Correctional Investigator (Correctional-Investigator, 2004)—a branch of the federal government responsible for overseeing the operations of CSC—have all found that women with mental health problems and those diagnosed with severe mental illness are most susceptible to coercive treatment.

Many sociologists, feminists, and women prisoner advocates have rejected the CSC's claim that women's prisons are now "culturally-sensitive," "woman-centered" or "empowering" to women prisoners (Balfour, 2000, 2006; CAEFS, 2002, 2005; Faith, 1993, 1995; Hannah-Moffat, 1999, 2001, 2004a; Hannah-Moffat & Shaw, 2000, 2001; Kendall, 2002; Micucci & Monster, 2004; Monture-Angus, 2002; Peters, 2003; Pollack, 2000b). Both Karlene Faith and Patricia Monture-Angus have argued that federal incarceration is particularly damaging to Aboriginal women. Faith, a feminist criminologist, professor and prisoner rights advocate since the 1960s, has argued that race and class play a significant role in the criminalization of women; Black women are

disproportionately criminalized in the U.S., while Aboriginal women are disproportionately criminalized in Canada (1993). In her essay on the development of the Okimaw Ohci Healing Lodge, she denies that the Lodge poses the possibility of “healing” Aboriginal women, arguing that “*any* state correctional institution colludes with the ideologies of penalty, which contradict all notions of healing” (1995: 81, italics in original). Monture-Angus, a professor of criminology, Native Studies and Law, who worked on the CSC’s Task Force on Federally Sentenced Women, has argued that the conditions for all federally sentenced women, especially Aboriginal women, have become worse since the Task Force’s report *Creating Choices* was written (2000). The failure to implement the values of *Creating Choices*, she argues, is particularly apparent with the Healing Lodge, because Aboriginal women are disproportionately classified as Maximum Security and therefore ineligible to be transferred to the Lodge (2002: 16).

The significance of inmate ‘health’ plays a large role in penal philosophy for several reasons. Primarily, the concepts of ‘correction’ and ‘rehabilitation’ are largely connected to definitions of ‘health’ and ‘healing’ according to CSC, criminologists and sociologists alike (although the ways in which ‘health’ is understood amongst and between feminists, criminologists, sociologists or the CSC may differ significantly). Furthermore, prisons are obligated to provide health services to prisoners, and prison staff are authorized to make decisions and declarations about inmates’ health which greatly impact the lives of prisoners. Such decisions are generally considered scientific, objective, and unquestionable, and consequently play a significant role in prisoners’ life behind bars and subsequent experience of their own health.

Micucci and Monster (2004, 2005), who have conducted empirical studies involving interviews with prisoners as well as staff in women's prisons in Canada, have shown that rehabilitation services, and mental health programs specifically, are inadequate to address the variety of needs of women inmates. Both inmates as well as mental health treatment providers reported that they did not believe that mental health programs had "rehabilitative potential" (Micucci & Monster, 2004: 11). Gillian Balfour (2000, 2006), a feminist criminologist who has spent her academic career researching criminalization in a Canadian context, has shown that feminist principles have been undermined in federal prisons, particularly therapeutic techniques which have become increasingly controlling under CSC's new "women-centered" model. Kathleen Kendall, a feminist criminologist who has studied mental health services provided to incarcerated women for over 20 years, and who has worked closely with CSC on mental health programming for women inmates since the early 1990s, argues that CSC's recent focus on women's mental health has resulted in the "pathologization of all federally sentenced women" (2000: 92). Lawyer Yvonne Peters specializes in Equality Rights and conducted a human rights analysis of CSC's treatment of women with mental disabilities for the DisAbled Women's Action Network Canada. In her analysis, Peters detailed numerous ways in which women with mental health problems and disabilities are discriminated against by CSC, and she concluded that "the capacity to create a therapeutic prison environment, conducive to healing, is antithetical to the purposes of the corrections system" (2003: 5).

The very idea that prison could be "woman-centered" is a paradox, argues Hannah-Moffat, because feminism envisions alternative practices to justice, namely, the

elimination of incarceration itself (Hannah-Moffat, 2004a). In fact, by claiming that feminist reforms have been adopted by CSC, federal women's penal regimes are further legitimized and shielded from critical evaluation (ibid.: 203). Overall, such criticisms of CSC argue that very little has actually changed when it comes to women's incarceration—most significantly, the ideologies of the 'new' penal regime continue to individualize women's problems, and hold women prisoners responsible for their own 'correction,' 'rehabilitation' and 'health.'

Feminist criminological theory provides an invaluable critique of CSC's practices, particularly by offering alternative ways of conceptualizing women's crime and experience in prison. Most significantly, feminist criminology illustrates that socio-economic and racial inequalities play a significant role in women's criminality, and therefore have significant implications for the structure of women's treatment in prison. While these observations serve as a departing point for my own research, there remain many gaps in this work that I seek to address in my own research. Many Canadian feminist criminologists have either been employed by CSC at some point or other, or have worked with incarcerated women directly, however, many of their studies fail to examine how CSC policy specifically facilitates discriminatory treatment of federally sentenced women. With the exception of Hayman's comprehensive examination of CSC's new federal women's prisons, *Imprisoning Our Sisters* (2006), few of these critiques refer to any specific policy or substantiate their claims with reference to CSC's documented governing practices. While I would not argue that this invalidates their conclusions, this thesis may be the first such project that seeks to examine these critiques through the very governing policies of the institution—the objectified texts that validate

and direct the organization of CSC's new era of women's prisons. Institutional Ethnography serves as a departure point to "map" the processes of institutions, in order to make visible the social relations that determine and organize institutional action. This methodology adds to these critiques by substantiating how institutional processes determine the problems that feminist criminologists identify.

One issue that is frequently discussed in feminist criminological research on CSC is the treatment of women diagnosed with mental illness. As mentioned earlier, some feminist research emphasizes the mental health problems of incarcerated women by asserting that the population "has" high levels of "mental illness" (see Peters, 2003; CHRC, 2003). These claims are an important contribution to critical criminology in that they challenge the psychiatric paradigm which assumes that mental illnesses are bio-medical 'diseases,' instead attributing mental 'illnesses' to past experiences of disempowerment and abuse. However, such claims fail to challenge the ways in which mental illness labels themselves can function as yet another source of social power, reflecting and reinforcing unequal power relations that subjugate women—it is taken for granted that such women possess an objective psychiatric "mental illness," even if it is explained sociologically. These studies may lead readers to conclude that such individuals have 'become' psychiatrically 'ill' as a result of victimization and abuse, potentially pathologizing the person's mental distress according to psychiatric definitions rather than social ones. While this distinction may seem subtle, the implications for treatments, therapies and the individual's own self-perception are enormous, as we will see later in chapter five.

Consequently, throughout this thesis I frequently replace a bio-medical definition of “mental illness” with the term such as “mental distress,” or “mental health problems.” This formulation undermines the medical and psychiatric interpretations of such distress, without denying the distress that many incarcerated women have been shown to have. Similarly, I often state that women “*have been diagnosed* with mental illness,” rather than that they “*are* mentally ill.” It is for this reason that a critical sociology of medicine is an invaluable part of the theoretical background employed in this thesis. It should be noted that some feminist criminologists have taken this position as well, and have criticized the use of some psychiatric practices in women’s prisons (see Pate, 2005; Kendall, 2000; Faith, 1993), and these critiques will be explored further in the following section.

Sociology of Medicine and Governmentality

Because ever greater numbers of women with mental distress are ending up behind bars (Peters, 2003; CAEFS, 2005; CSC, 2007; Huber, 2007), the sociology of medicine and feminist criminology are increasingly integrated into sociological analyses of women’s prisons. Both feminist criminologists and sociologists of medicine have taken up prison health services as a matter warranting inquiry and scrutiny. The sociology of medicine offers a glimpse into the nexus of power relations which shape individuals’ experience of ‘health’ and ‘illness.’ The central concern of the sociology of medicine is not individuals’ purportedly objective health ‘needs,’ but the ways in which medical ‘knowledge’ is constructed and applied to individuals. Medicine is seen as both a product and reflection of social forces, and thus reproduces and reinforces dominant social

ideologies and discourses (Wright & Treacher, 1982: 5). The sociology of medicine calls into question the assumptions of western bio-medical practices:

No strictly objective and value-free view of the biological world exists. Any attempt to explain it or order it will be shaped by the historical and cultural setting within which it occurs. (Lippman, 1991: 17)

Instead of being an objective discipline that refers to a “pre-existing external reality,” medicine is understood as a “discourse which constitutes its own subjects” (Wright & Treacher, 1982: 7). The construction of illness is understood as an arbitrary process as medical categories transform and shift what criteria constitute a “disease” (Bowker & Star, 2000). Medicine must do the work of “fitting in” symptoms, experiences, test results, and patterns into disease categories (Zyporin, 1992: 56). This process depends on the convenience of pre-established disease classifications, and subjective decisions by medical professionals (ibid.).

Individuals’ health is constructed through the imposition of the medical model as their experiences come to be defined by medical ‘knowledge.’ This process is referred to as “medicalization” (Conrad, 1992; Lorber & Moore, 2002: 6), whereby “nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorder” (Conrad, 1992: 209). Disease is understood according to a western bio-medical doctrine which focuses on illness as an objective and measurable phenomenon that “is a deviation from normal physiological functioning” (Lorber & Moore, 2002: 2). The goal is to alleviate symptoms, usually through technological and scientific research and treatments.

Some sociologists of medicine have argued that the expansion of medicine into ever increasing realms of private life solidifies established mechanisms of social control

(Conrad, 1992; Timmermans & Gabe, 2002); medical professionals possess power through their authority to define problems and legitimate medical intervention in increasing aspects of life. While the medical community accumulates authority, however, social problems become decontextualized, individualized, and put under the control of medicine (Conrad, 1992: 224). Particular individuals or groups, such as women, become vulnerable to over-medicalization or coercive medical practices which go unchallenged by the population at large and the medical profession itself (Conrad, 1992; 222).

Forms of social deviance and “abnormality” are particularly vulnerable to medicalization. Conrad points out that behaviours subject to medical social control are often subjected to other forms of governance, specifically, he mentions, behaviours defined through a “medical-legal” hybrid lens (1992: 218) such as gambling, addiction, and some expressions of sexuality. Conrad’s theory supports the claim that both the law and medicine play an enormous role in regulating and prescribing socially acceptable behavior by constructing and enforcing legal and medical ideologies upon populations.

The shift towards a tighter association between ‘professional’ disciplines such as medicine and law has been increasingly attributed to neo-liberal governmentality.

Foucault identified governmentality as a form of power which performs the administration of society through the coordination of institutional procedures and tactics by generating and employing bodies of professional “knowledge,” or “savoirs” about the population (1991: 103). Governments develop a relationship to knowledge of human conduct that makes possible a population’s own self-governance (Reuter, 2007: 14; Rose, 1996). Power is intimately connected to knowledge, or “power/knowledge,” which “both constitutes and is constituted through” professional discourses (Carabine, 2001: 275) and

expertise. Organizations and institutions, then, are responsible for managing and constructing individuals' subjectivity. Institutions (with their institutional knowledge and their institutional goals) have supplanted the state proper by performing the role of intervening in, and managing the private lives of citizens, such as medicalizing social problems (Rose, 1991: 2, 3). The authority of various expertise, such as the psy-sciences, is central to this process. In the case of medicalization, individuals become the doctor to themselves (Foucault, 1988: 31) by taking responsibility for, and playing an active role in, their own health (Rose, 2001: 6). Populations employ "technologies of the self" which "permit individuals to effect...operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1988: 18). Individuals are thus bound to expert knowledge "as a matter of their own freedom" (Rose, 1996: 58).

Psychiatry, amongst other psy-sciences, plays a large role in "prescribing normative codes of behavior" (Scott, 2006: 135). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 1994)—the "bible" of psychiatry's mental illness and disorder classification system—operates as the scientific basis of the psy-disciplines by projecting an appearance of objectivity and neutrality (Reuter, 2007: 21). The *DSM*, then, becomes a "technology of normalcy" (Gleason, 1999; quoted in Reuter, 2007: 21) by delineating the classification of "normal" and "abnormal" human conduct upon which mental illness diagnoses are based. By having the authority to identify the very basis of "abnormal" and "disordered" behaviour, psychiatry constitutes a powerful disciplinary force which governs the everyday lives and practices of individuals (Kendall, 2000: 86).

The disciplinary power of medicalization compliments that of the prison. Prison settings impose “technologies of the self” on prisoners who are increasingly responsabilized for their activity in modern penal regimes (Garland, 1997; Timmermans & Gabe, 2002). Power is enforced through the acquisition of medical and penal knowledge about prisoners which then serves as the basis for the justification of social control (Foucault, 1995; Timmermans & Gabe, 2002). The role of incarceration and medicine are conflated in modern prison, since they both take on the objective of facilitating “rehabilitation” (Timmermans & Gabe, 2002: 508).

Foucault and others have shown that penal regimes shifted throughout the centuries from punitive, to welfarist, to neo-liberal (Foucault, 1995; Garland, 1997: 174). In *Discipline and Punish* (1995), Foucault illustrates the genealogical shift in penology’s object of interest and punishment from the body to the mind. By the early 19th century, obligatory medical treatment and intervention became a guiding tenet of prison policy (Foucault, 1995: 18). More recently, “correction” and “rehabilitation” have been the purported function of prisons, as evidenced by the use of the term “correctional institutions” to supplant “prisons,” such as the “Correctional” Service of Canada. Foucault’s genealogy of the development of “docile bodies” (1995) and social disciplinary practices more broadly have been widely appropriated by sociologists, and expanded to understand the medico-psychiatric production of “patient bodies” (Timmermans & Gabe, 2002: 506). This concept implies that incarcerated individuals diagnosed with psychiatric conditions are neither just prisoners nor just patients, but “prisoner/patients,” both morally bad and mad, and are compelled to undergo strict and regimented discipline to transform both their ‘criminality’ and their ‘mental health.’

Feminists have long been critical of psychiatry's construction and treatment of women (Reuter, 2007: 10; D. Smith, 1975), not least because women have been particularly vulnerable to having their problems cast as "pathological conditions" (Wright & Treacher, 1982: 1). Foucault's concept of governmentality provides a valuable framework for criminologists and feminists to understand women's criminalization and medicalization; particularly the ways in which both operate in tandem, simultaneously serving disciplinary and regulatory forces. These theories offer insight into how medical ideologies may reinforce power relations in institutional settings such as prisons, or more broadly, in society at large.

Feminist Analyses of CSC's Mental Health Practices

In both Canada and the U.S., economic cutbacks to social programs over the past three decades have caused gaps in community-based care facilities for people with mental health problems. Increasingly, individuals who have been diagnosed with mental illnesses are ending up behind bars (Micucci & Monster, 2004; Timmermans & Gabe, 2002: 512). The DisAbled Women's Action Network of Canada has declared that "prisons have become the modern day version of non-voluntary mental institutions and asylums" (Peters, 2003: 22). This "trans-institutionalization" affects women most severely, who have traditionally been overrepresented in psychiatric institutions (Peters, 2003: 5).

Once incarcerated, federally sentenced women with psychological issues experience a variety of problems. Women diagnosed with mental illness are more likely to be labeled as having "disciplinary problems" (Peters, 2003: 5) and are more likely to be subjected to "over-classification." Some academics and advocates of federally sentenced women have pointed out that the CSC conflates possessing greater health

needs with being a greater security risk (CAEFS, 2002: n.p.; Hannah-Moffat, 1999, 2001; Peters, 2003: 5). This may involve being moved into higher security prisons where they can be more strictly controlled, or being placed into segregation and isolation (CAEFS, 2002: n.p., 2005: 4; Peters, 2003: 5), all of which may compound their mental instability.

CSC's women's health services have been subjected to diverse criticisms. These criticisms tend to highlight two simultaneous problems with health services. On the one hand, CSC's health services have been accused of failing prisoners by lacking adequate or substantial long term treatments and therapies (CHRC, 2003: 40; Correctional-Investigator, 2004: n.p.). On the other hand, CSC has been accused of over-medicalizing prisoners for the sake of management and control (Faith, 1993: 234; Hannah-Moffat & Shaw, 2001: 51; Peters, 2003: 6). These two perspectives may seem contradictory at first glance, in that one argues for increased medical services for prisoners while the other argues for decreased medical services. What remains consistent, however, is the recognition that incarcerated women have particular mental health issues that arise from their past experiences of abuse and poverty, as well as high rates of substance use (CHRC, 2003: 35; Peters, 2003: 7; Thomas, 2003: 4). Not only are women more likely than men to arrive in prison with mental health problems, they are more likely to endure mental health problems while incarcerated (CHRC, 2003: 35; Maeve, 1999: 50; Nicholls *et al.*, 2004: 168).

The treatment of women with apparent and severe psychological problems is undoubtedly an important issue. Historically, feminist criticisms of women's incarceration have called for better mental health services for women in psychological distress and the CSC has responded to these critiques by greatly reforming women's

health services over the past 15 years. According to the literature on CSC's policy reforms, however, such changes have simply introduced new and different problems. First, by 'improving' services through reform, both incarceration and health services in prisons become subtly justified. By adopting a discourse of "woman-centered" and "empowering" health care, researchers are less likely to challenge penal philosophy itself, or critique whether incarceration is a justifiable and adequate means of dealing with women who find themselves in conflict with the law (Faith, 1995: 88; Hannah-Moffat, 2004a: 301). In addition, and perhaps more interestingly, calls for "better" health services fail to recognize how federally sentenced women, whether officially diagnosed with a mental illness or not, are over-medicalized in problematic ways.

— Faith (1993) argues that, like incarceration itself, the medicalization of women prisoners contributes to the individualization of their problems by decontextualizing the social conditions which impact their mental well-being. Prisoners' problems are placed under medical control, and understood by the prison through a medical and penal lens, rather than a sociological one (Faith, 1993: 175). Medicalization holds women responsible for their own health by assuming that women's behaviour is "irresponsible" and "an individual maladjustment to a well-ordered and consensual society" (Smart, 1976: 145). Kendall, who has worked for the CSC in two different capacities, including evaluating women's programming in the early '90s, has severely criticized the use of the "psy-sciences" in women's federal prisons. She asserts that mental health services obscure and maintain power relations within prisons by serving a disciplinary and regulatory role, shaping and controlling the everyday practices of prisoners (Kendall, 2000: 83, 86). According to Kendall, the recent emphasis on 'correction' in penal

institutions, and CSC's interest in the 'mental health' of prisoners "has resulted in the pathologization of all federally sentenced women and the creation of the severely mentally-disordered female prisoner" (2000: 92).

Several studies reveal that prisoners are immediately subject to medicalization upon intake into the prison through a series of mental health and psycho-diagnostic assessments. Nicholls et. al's study comparing two types of programs used to diagnose women entering federal prison demonstrated that the purpose of such an intake strategy is not only to determine the institution's health care provision, but interestingly, to "protect professionals and institutions against civil liabilities" (Nicholls et al., 2004: 169). Such procedures are admittedly interpreted by the CSC to ensure that more people are falsely diagnosed with a mental-illness rather than failing to identify those that would normally be diagnosed with a mental illness (Nicholls et al., 2004: 170). These procedures also seek to identify to whom the institution will choose to prescribe psychotropic pharmaceuticals, and who it will commit to psychiatric facilities involuntarily (Nicholls et al., 2004: 179). These findings may lend evidence to the claim that women are more often over-diagnosed with mental illness and over-prescribed medicine, possibly for the sake of control, and more likely to be labeled mentally ill and prescribed pharmaceuticals than male prisoners (Faith, 1993: 234; Hannah-Moffat & Shaw, 2001: 51).

A commonly articulated concern for some researchers has been that mental health services serve to pathologize women while ignoring socio-politico-economic explanations for their behaviours or the role that prison plays in their psychological distress (Hannah-Moffat, 2004b: 377; Kendall, 2000: 90). The Canadian Association of Elizabeth Fry Societies, for example, found that women with past experiences of abuse

and victimization are more likely to be labeled with particular mental disorders, such as Fetal Alcohol Syndrome, Schizophrenia, or “psychosis” (CAEFS, 2005: 14). In response to the rate at which incarcerated women are diagnosed with personality disorders, CAEFS (2005) has challenged whether these labels are either useful or accurate for women who have endured histories of abuse. In both provincial and federal prisons, women are frequently diagnosed with some form of personality disorder, Aboriginal women being the most vulnerable to such diagnoses (CAEFS, 2005; Micucci & Monster, 2005: 177; Pollack, 2000b: 74). Researchers have noted that the labeling of Aboriginal women with Dependent Personality Disorder, which is purported to arise from their historical “dependence on non-Aboriginal institutions” (TFFSW, 1990: 56), reflects racist institutional assumptions because it treats the “illness” as a “character trait that can be addressed through therapy and programming” (Pollack, 2000b: 74). If women with past histories of poverty and violence are more vulnerable to having their “social disadvantage [translated] into pathologies” (Correctional-Investigator, 2004: n.p.), according to the CSC’s own Correctional-Investigator, then Aboriginal women should be particularly vulnerable given the demographic history of most Aboriginal women in federal prison. Indeed, a few psychiatric labels applied to Aboriginal women in prison have been cited as particularly problematic and racist, including Dependent Personality Disorder (Pollack, 2000a) and Fetal Alcohol Syndrome (Pate, February 21, 2006).

Several studies on mental health services in women’s prisons have concluded that Aboriginal women experience even greater vulnerability to medicalization and social control in prison because they are more likely to be ‘classified’ in various ways (as maximum risk, mentally unstable, etc) (CAEFS, 2005: 4; CHRC, 2003: 28; Correctional-

Investigator, 2004: n.p.; Monture-Angus, 2002: 16). Calls for alternative methods of treatment for Aboriginal women eventually led to the CSC's creation of the Okimaw Ohci Healing Lodge in Saskatchewan. However, it has been argued that the "healing lodge" more closely resembles a Maximum Security prison than an open community of support and healing, and that the local Aboriginal population actually has little say in its operation (Monture-Angus, 2000: 18). Furthermore, the healing lodge does not have enough space for all of Canada's Aboriginal women inmate population (the capacity is 28) (CAEFS, 2005: 15; Faith, 1995: 79) given that Aboriginal women constitute 30% of federally sentenced women (CAEFS, 2005: 15) and that Caucasian women compose approximately 16% of the Healing Lodge population (CSC, 2004: n.p.). Access to the healing lodge is further impeded because of Aboriginal women's over-classification (e.g. in Maximum Security, isolation, etc). Women with Maximum Security classification are not eligible to be transferred to the Healing Lodge, yet Aboriginal women are disproportionately placed in Maximum Security (Monture-Angus, 2002: 16).

A common complaint regarding programming for Aboriginal women being housed outside of the healing lodge is that they are not treated with sensitivity towards their cultural needs and preferences since the concept of "rehabilitation" is a eurocentric concept absent in Aboriginal cultures (CHRC, 2003: 51). In Monture-Angus' research on federal women's prisons (2000, 2002), Aboriginal women reported that when they refuse institutional, western bio-medical treatments, they are often regarded as uncooperative. She concluded that Aboriginal women are particularly vulnerable in prison because they may not be interested in programming that does not respect conventional healing

traditions of their culture, and additionally, they are more likely to be disciplined or further classified for resisting medicalization.

The treatment of female prisoners' mental health is mandated through the CSC's *2002 Mental Health Strategy for Women Offenders* (Laishes, 2002). The strategy has been greatly criticized by feminist researchers for advocating therapeutic models which ignore the class, gender and racial contexts behind women's criminal acts, and individualizing them as their own responsibility, or as results of psychological and cognitive problems (Balfour, 2000; CAEFS, 2002, 2005; Hannah-Moffat, 2004b: 377; Kendall, 2002). Kendall (2002) suggests that certain therapeutic programs reinforce androcentric prison policy because the therapy blames the individual for misdeeds and ignores the social contexts of women's crimes. CSC employs Dialectical Behavioural Therapy (DBT) to female prisoners, a therapy that was originally developed for Borderline Personality Disorder (Kendall, 2000: 90). DBT has been accused of individualizing women's crime, pathologizing women, invalidating their refusal to cooperate, and blaming them for 'failing' in the prison system (CAEFS, 2002: n.p., 2005: 13; CHRC, 2003: 39; Kendall, 2000: 93). The Canadian Association of Elizabeth Fry Societies and the Canadian Human Rights Commission argue that DBT (unintentionally) produces dependency in women because it teaches them to abandon or "re-think" the very strategies used to survive difficult situations they may face upon release (CAEFS, 2005: 13; CHRC, 2003: 39). Moreover, the therapies do little to recognize how the prison environment itself produces and exacerbates mental instability (Kendall, 2000: 91).

The other serious critique of psychiatric treatments is the coercive nature of women's participation (Hannah-Moffat, 2004a: 300). Prisoners who refuse to cooperate

with pharmacological treatments may be subject to disciplinary actions or have security restrictions placed upon them (Hannah-Moffat & Shaw, 2001: 51). Maeve (1999: 63) notes that prison health staff are able to employ subtle strategies to coerce women to participate in psychiatric treatments to which prisoners have no recourse to resist, even if they are not 'obligated' to comply with health professionals. The coercive nature of prison therapies within the CSC has resulted in the Canadian Association of Elizabeth Fry Societies' condemnation of such practices. The organization argues that women are not "choosing" to participate freely, especially women who have significant mental health problems for whom these therapies may be better suited (CAEFS, 2005: 13). Hannah-Moffat (2004a) argues that effective therapy is contingent upon providing the participant with a sense of power and self-determination, whereas prison settings are contingent upon removing any self-determination whatsoever. These arguments indicate that the application of mental health services and therapeutic techniques perform a regulatory role, and are used to serve the interests of the institution rather than the prisoners themselves.

Many have argued that Aboriginal prisoners in particular, as well as women with mental health problems or cognitive problems, are better off being healed and 'corrected' in their own communities, rather than behind bars (Balfour, 2000: 101; Correctional-Investigator, 2004: n.p.; Peters, 2003: 20). In recognition that CSC is more likely to reform health services than relinquish incarceration of women regardless of their mental health status, some feminist scholars (Balfour, 2006; Pollack, 2000b) have called for the replacement of CSC's therapies with "alternative, anti-oppression approaches" which recognize "women's experiences of systemic, interpersonal, and structural oppressions"

(Balfour, 2006: 744). It has also been suggested that “peer support, training that continues into the community, harm reduction measures and non-judgmental counseling” (CHRC, 2003: 39) could be more a more effective strategy for treating women inmates with mental health problems.

Overall, feminist criminology literature consistently reiterates that, ultimately, prison is antithetical to healing psychological distress and mental ill health. Researchers has shown that prison can cause or exacerbate mental distress for women in prison (Kendall, 2000: 91; Nicholls et al., 2004: 91)—particularly those with past histories of abuse, violence and poverty who possess less psychological stability to cope with such conditions. In general, feminist criminologists have characterized the environment negatively, concluding that it is ultimately contingent upon “confinement, surveillance, classification, discipline” (Faith, 1995: 81), “humiliation, suffering” (Maeve, 1999: 66), “power and control” (CAEFS, 2002: n.p.), “punishment and...dehumanization” (Faith, 1993: 229), and thus fails to heal and properly care for women prisoners (CAEFS, 2002; Faith, 1993, 1995; Ferraro & Moe, 2003: 78; Kendall, 2000: 90; Maeve, 1999).

The sociology of medicine provides theoretical tools with which to challenge the often undisputed assumptions of the ‘psy-sciences.’ It allows researchers to understand medicine as a sociological process rather than a biological one, illuminating how medicine is socially constructed, and how it shapes the social world thereafter. Sociologists of medicine conceptualize medical practice as both a product and a reflection of social forces, and investigate the dominant ideologies and discourses that are reinforced through medicine’s application. Within a carceral, or ‘correctional,’ context, this theory provides an understanding of the ‘psy-sciences’ as an expertise which

instructs individuals to govern themselves. Genealogies of prisons by governmentality theorists illustrate that prisoners are increasingly 'responsibilized' for their crime and their individual 'correction,' as well as their mental health and 'rehabilitation,' giving prisoners a hybridized status of 'prisoner/patient.' However, as we have seen, this process also serves to decontextualize and individualize crime and mental distress, supplanting social explanations for criminality and mental ill health with bio-medical and pathological definitions of individuals' conduct.

Many feminist criminologists have employed sociological critiques of a variety of medical and psychiatric practices within the CSC. Some feminist theorists have criticized CSC's treatment of women with mental health problems, arguing that they are unfairly classified and mismanaged in prison. Others, however, are challenging the very basis of psychiatric 'knowledge' in women's prisons, suggesting that mental health services serve to pathologize women inmates by constructing them as 'disordered' and 'mentally ill.' These criticisms identify power at the heart of medical practices in women's federal prisons, illustrating that discursive processes serve greater ideological functions by reinforcing dominant ideologies of social inequality. While these arguments contribute a great deal to the literature by explaining how power operates in women's federal prisons, they often fall short of examining actual prison processes and policies. These arguments would be strengthened if they included an analysis of how power may be textually mediated through the actual governing documents of the CSC.

While sociological analyses of medicine are useful for identifying power within medical practice as a diffuse web, operating through discursive constructions of 'health' and 'well-being,' they largely fail to account for the practical, everyday 'reality' of power

for those subjected to ‘expertise’ within institutions. While this perspective may tell us much about how power may be conceptualized as a discursive process, it must be supplemented with theoretical tools that investigate “how things happen” (Campbell, 2003) in reality—in this case, in CSC’s actual prison practice. Feminist criminology and Institutional Ethnography may both be used to explore institutional processes, illustrating the power that exists through institutional practice beyond that of discourses, and locating sexism, racism and classism at the heart of CSC ideology. By supplementing feminist criminological analyses and sociological analyses of medicine with an institutional ethnographic approach, this thesis will illustrate how power is objectified in CSC’s women prison policies, legitimating social inequalities through discourses and ideologies throughout its prison policy texts.

Institutional Ethnography

Institutional Ethnography is an approach developed by Dorothy Smith, who outlines the methodology in her books *Institutional Ethnography: A Sociology for People* (2005), and *Institutional Ethnography as Practice* (2006a). Institutional Ethnography must be considered both a theory and a methodology since it makes ideological assumptions about the social world while providing a sociological method with which to analyze it. The purpose of Institutional Ethnography, according to Smith, is epistemological; it is to “reorganize the social relations of knowledge of the social” (2005: 29), and to discover and map “the social as it extends beyond experience” (2005: 10). As such, the approach seeks to provide an alternative to ‘scientific’ and objective forms of knowledge in the social sciences as well as the ‘knowledge’ produced within institutions themselves.

Institutional Ethnography as Theory

Institutional Ethnography has its roots in Ethnomethodology, which inquires how subjects relate to social order knowledgeably, or in “everyday” and “common sense” ways, and through their participation local sites of social order are established and accomplished (Campbell & Gregor, 2004), such as how individuals appear to naturally queue themselves in order to board a bus. The emphasis in Ethnomethodology is on the person herself, coordinating her actions with the social world, rather than on a reified social order “over and above” her (D. Smith, 2005: 2). Social settings are posited as “self-organized,” and features outside the local setting of social order (which may nonetheless shape its organization) may be treated as beyond the topic of inquiry (Grahame, 1998: 350). Social patterns are isolated from their contexts as though they are self-contained, and wider systems of organization are negated in order to investigate the local setting of activity (ibid.).

Both ethnomethodologists such as Zimmerman (1975) and institutional ethnographers recognize that institutions, organizations, or bureaucracies cannot be understood or studied without an analysis of the significant role of texts. Institutions rely heavily on texts and documents (Namaste, 2006: 160; Zimmerman, 1975) by producing and constructing what the organization sees as legitimate knowledge. Modern “politico-administrative regimes” (G. W. Smith, 2006b: 62) are organized around texts and are characterized by the “collection, production, and use of records” (Zimmerman, 1975: 128). Institutional records are seen as the paramount source of objectively-established, factual information, while, in contrast, the factuality of claims made by those subjected to institutions is not assumed as apparent (ibid.). Instead, the institution imposes its own

requirements to establish factuality through textually-based evidence such as bureaucratic statements, reports, certificates, etc. (Zimmerman, 1975: 129). Bureaucratic documentation takes precedence over what the institution sees as “problematic and challeng[ing]” claims made by individuals (Zimmerman, 1975: 142). “Legitimate” facts are established by appealing to authoritative and independent sources of information, while the individual’s facts carry no authority of their own (Zimmerman, 1975: 132, 133).

While ethnomethodologists understand the researcher to be limited to an inquiry from inside the local site of social organization alone, Smith developed Institutional Ethnography as a method to investigate *how* social order is established beyond that point, translocally, which includes the standpoint of those within the order itself. Smith centralizes the role of texts as the source from which individuals infer meaning, although emphasis is not placed on “meaning as if it occurred independently from perceiving subjects” (McCoy, 1995: 181), as it may be in Ethnomethodology. Rather, texts are examined for how they compose social relations and determine the contexts “in which individual acts of interpretation are possible, and occur—along with their consequences” (ibid: 182). Ethnomethodology may be useful for understanding how individuals produce the social sites in which they participate, but it fails to account for broader systems of organization in which the acts themselves are embedded. For example, individuals queuing for the bus may not be particularly interesting to institutional ethnographers as an isolated account of social activity. However, they may be interested in such a process during racial segregation, when people of colour were “queued” to the back of the bus. This seemingly “natural” social act could then be linked to how such practices were

facilitated by transit systems, and then how this “work” was embedded in ideological projects of class and race segregation more broadly. The standpoint of those enduring racial segregation through such practices could then be connected to textually-mediated institutional ideology.

The aim of Institutional Ethnography is to make textually-based power observable; power can be revealed through textual analysis for the ways in which it constitutes subjects and establishes their agency (D. Smith, 2005: 183). People, in their everyday lives, are subjected to the power of textually-mediated institutions, either through their work within institutions in which they coordinate their own actions with those of ruling regimes (Campbell, 2003: 12), or through the complex ways in which individuals are “subjected to institutional actions by being fitted to institutional categories” (D. Smith, 2005: 199) such as Consumer, Student, Welfare Recipient, Patient, Municipal Citizen, Inmate, etc.. These “categories” are textually-mediated and serve the interests of the ruling regime. People may be processed, not as individuals, but as “categories of persons” that are defined by institutional discourses (D. Smith, 2005: 120).

People are subject to a variety of administrative regimes in their everyday lives. They compose the “ruling relations” (D. Smith, 1990a, 1990b, 2005; D. Smith, 2006a) of society; the “corporations, government bureaucracies, academic and professional discourses, mass media,” etc. (D. Smith, 2005: 10) that organize and govern social relations. The ruling power of institutions emerges from their interconnectedness—for example, a corporation does not possess power in a vacuum, but rather holds power through its association with other ruling relations such as government and the media

(ibid.). To “rule” is to possess the power to shape people’s activities and govern their everyday lives (Campbell & Gregor, 2004: 32).

Importantly, Smith understands the ruling relations of institutions to be “textually-mediated”, meaning that their organization through texts coordinates individuals within them—both those working inside, and those subject to, the institution (D. Smith, 2005: 183). Texts mediate the lives of the ruled, and “subordinate local knowing, imposing [the] ruling perspectives” (Campbell, 2003: 16). Institutional texts do not privilege the voices of the people, but rather subordinate them so that the person may become “institutionally actionable” (D. Smith, 2005: 187). This process often involves the interrogation of the subject, who becomes objectified in texts through their classification in bureaucratic policy. Texts “occur” and “activate” social settings, coordinating the processes of the institution and initiating sequences of action (D. Smith, 1990a: 224, 2005: 180; D. Smith, 2006a: 67; G. W. Smith, 2006b: 54). They possess power by binding people together and shaping the ways in which individuals, unknowingly, relate and behave in concert with one another and with the goals of the institution (Campbell & Gregor, 2004: 32).

Institutions employ “frames” as the foundation for the interpretation of individuals and their circumstances. Frames are employed throughout all levels of textually-based institutional action in the production of objectified institutional knowledge and facts: “Frames govern the selection of what will be recorded, observed, described, and so on. In some institutional settings, they are specified as categories used at the front line in the work of interrogation; they are built into the technologically refined sets of questions or ratings...” (D. Smith, 2005: 191). Such practices constitute

knowledge-based “technologies of ruling” (Campbell, 2003: 16). This concept is not far from the observation by governmentality theorist Nikolas Rose that, increasingly,

Organizations have come to fill the space between the ‘private’ lives of citizens and the public concerns of rulers. Offices, factories, airlines, colleges, hospitals, prisons, armies and school all involve the calculated management of human forces and power in pursuit of the objectives of the institution. (Rose, 1991: 2)

Institutions also generate facts through the observation, supervision and surveillance of individuals. Supervisors may be compelled to observe employees’ activities within the institution in order to ensure they are adequately coordinated with the goals of the institution (Zimmerman, 1975: 130). Similarly, those within the institutional system may be surveilled or observed so that their behaviours and activities can be known, managed and documented. This form of surveillance and observation is particularly relevant in both medical and penal contexts (Conrad, 1992: 214; Foucault, 1995; Rose, 1991: 7; Timmermans & Gabe, 2002: 506).

Institutional Ethnography as Practice

Institutional Ethnography, as a practice, involves three goals, or “tasks,” according to Peter Grahame (1998: 353). The first goal is to connect institutional processes with ideology. Institutions appeal to ideological forces, and their operations are thus concerted with wider ideological goals. Institutional ethnography seeks to identify broader ideological prescriptions which shape and organize institutional practice. The second goal addresses the role of “work” in institutional settings. Smith adopts a broader definition of “work” beyond formal paid employment, which includes how individuals reproduce the environment in which they are embedded, how their actions are coordinated with one another, and how these serve the goals of the institution. The final

goal of Institutional Ethnography involves examining social relations to discover how local sites of order are organized and coordinated more broadly through translocal social relations, and how such processes are linked.

Institutional Ethnography follows from local sites to extra-local forces (D. Smith, 2005: 35) and aims to uncover the foundational forces behind local microsocial processes that are invisible from the perspective of the local setting alone (D. Smith, 2005: 36). The object of inquiry is not the everyday experience of individuals within institutions, but rather the textually-based processes and forces within and beyond the institution that ultimately shape people's experiences (D. Smith, 2005: 38). Institutional Ethnography obliges the sociological researcher to take up texts as the central object of analysis and enquiry. Texts mediate the processes and everyday practices of the institutional world (Campbell, 2003: 12; D. Smith, 2005: 10) and serve as the "entry points" (Campbell & Gregor, 2004: 81) to investigate the ruling relations of the institution. Texts indicate the "translocal social relations and organization" (D. Smith, 2006a: 65) that dictate the institution's local, day-to-day structure.

The 'facts' and 'knowledge' produced by an institution are recorded in its texts, documents and records. They must be "interrogated" (Campbell, 2003: 6) and subjected to analysis in order to produce an account of the day-to-day practices of the institution (Turner, 2006: 139). Texts are understood to *occur*; to be embedded in what is happening inside the institution (D. Smith, 2006a: 67). The purpose of Institutional Ethnography is to empirically incorporate texts into a map of how they both "occur," and "coordinate institutional courses of action" (D. Smith, 2005: 180; D. Smith, 2006a: 86). Because texts and actions organize the institution circularly, texts cannot be read linearly or

continuously. Instead, “they are read selectively for different purposes...and it is these selective readings for which the text is constructed and which, in a sense, analyze it to find the sense it can make in particular settings of action” (D. Smith, 2006a: 68). The selection of particular texts as data is inspired by theory, and linking the data with theory occurs explicitly during the analysis (Campbell & Gregor, 2004: 81). Consequently, it is not possible to predict exactly how each text will be analyzed beforehand. Rather, its analysis involves how it fits in to other texts hierarchically, outlining and determining the processes of the institution.

Texts operate through a process Smith describes as “intertextual hierarchy” (2005, 2006a); that is, the ways in which “higher-order” texts regulate “lower-order” texts by providing the rules and frames through which they are understood and activated by people, although not necessarily knowingly, in the process of their work. Within the intertextual hierarchy, the function of lower-order, or “subordinate” texts is ascribed by “higher order,” or regulatory texts (D. Smith, 2006a: 85), and the sense it makes to people is found in the interpretative frames established by the regulatory text (*ibid.*: 87). Thus, regulatory frames of institutional discourses fulfill two functions. They determine the “categories, concepts, and methods” adopted by institutions, and they provide “instructions” on how texts are to be interpreted by people during “text-reader conversations” (D. Smith, 2005; D. Smith, 2006a) in the process of their work. In so doing, regulatory frames compose the “scripts” which produce the everyday activities of institutions “from the actualities of people’s lives” (D. Smith, 2005: 187). For example, George Smith’s (1988, cited in D. Smith, 2005) analysis of a police report which translated the sexual activities of a group of gay men at a Toronto bathhouse into a

criminal act for which all could be held criminally accountable, illustrated how the police officers involved selectively drew from the criminal code to produce the report and establish a criminal frame. The specific “facts” produced in the report were intended to subsume the actualities of the individuals’ lives and fit into institutional categories so that they be understood as criminal, thus enabling charges to be brought against them (D. Smith, 2005: 195).

Institutional ethnographers conduct ethnography by examining ruling relations as they emerge from materially-based texts activated in text-reader conversations in the process of people’s work (D. Smith, 2005: 184). Once institutional processes are mapped through their intertextuality, then “it becomes possible to trace connections that might otherwise be inaccessible,...the organization of powers generated in the ruling relations” (D. Smith, 2005: 181). By exposing links that exist between levels of texts and data (Campbell & Gregor, 2004: 81), the power behind ruling relations becomes illuminated as “a complex and massive coordinating of people’s work” (D. Smith, 2005: 183) through particular institutional discourses.

Institutional Ethnography aims to make power ethnographically observable, for how it both coordinates people’s work, as well as how it fits individuals into institutional categories articulated in regulatory texts. These texts “authorize and subsume...the actualities of people’s experience...imposed by the regulatory frames” (D. Smith, 2005: 199). Smith cites (2005: 189) a study by McLean and Hoskin in which a Needs Assessment form concerning hospital patients was filled out by nurses without the participation of the patients themselves. In subsequent discussions and texts produced from the Needs Assessment that had been administered regarding particular patients,

community workers then “objectively” determined the level of “need” experienced by the patient, again, without input or participation from the patients themselves. While the patient’s own sense of need played no role in determining the outcome of their care, their needs were determined by the workers responding to the questions outlined in the Needs Assessment form, which shaped their allocation to particular departments within the hospital. Institutional Ethnography illuminates how such forms, or Smith’s bathhouse police report, “are designed to select from the actual that which fits the institutional frame” (D. Smith, 2005: 199), and facilitate consequent institutional action.

Institutional Ethnography: Prisoners and Patients

Institutional Ethnography is a highly applicable methodology to investigate prison health services because the process of institutional categorization is fundamental both within medicine and prison environments. Smith has spent much of her academic career interrogating the “social science” of mental illness. She has argued that institutions “employing” mental illness categories control people’s “troubles” by fitting them in to a prescribed system according to “standardized terms and procedures” (1990b: 125). Such actions are essential to the institution and impact policy, including the ways it produces its ‘facts,’ such as statistics. This is not to say that mental illness is caused by psychiatry so much as that the form that ‘mental illness’ may be characterized by the social contexts produced by psychiatry (D. Smith, 1990b: 122). To understand institutional ‘facts’ about mental illness then, one must take into account that the character of mental illness is determined and understood by the psychiatric agencies themselves, and not merely by the “reality” of mental illness (ibid.).

According to Smith, understanding mental illness becomes a circularly referential process, in which institutional staff make psychological analyses according to the paradigm of institutional knowledge even before the involvement of psychiatric professionals. Smith argues that

The various agencies of social control have institutionalized procedures for assembling, processing and testing information about the behavior of individuals so that it can be matched against the paradigms which provide the working criteria of class-membership whether as juvenile delinquent, mentally ill, or the like. These procedures, both formal and informal, are a regular part of the business of the police, the courts, psychiatrists, and other similar agencies. (1990a: 12)

The “conceptual work” of identifying someone as mentally ill involves appealing to an understanding of mental illness that itself assumes a “relationship between rules and definitions of situations on the one hand and descriptions of [mentally ill type] behavior — on the other” (D. Smith, 1990a: 48). Texts facilitate this process by providing a “pathologizing interpretive frame” whereby texts offer “contextually isolated accounts of the subject’s behavior” so that the behavior is interpreted as symptomatic of some pathology (D. Smith, 2006a: 78).

Psychiatric and/or medical records “do not merely mirror medical practice but play an active, constitutive role in current medical work” (Timmermans & Gabe, 2002: 508). The health of the patient becomes a textually classified and mediated world of its own, as behaviour and illness become defined so that they may be ‘acted upon’ accordingly. The ‘patient’ (or prisoner) does not participate in this process—their “needs” are determined objectively and independently from their desires (D. Smith, 2005: 189). The available frames are already determined by the text, so that the text itself becomes

regulatory (D. Smith, 2005: 191), and the patient is acted upon according to these available institutional categories.

Translating people's lived realities into institutionally processable categories often involves interrogation (through such documentation as forms and surveys) or surveillance of the subject (D. Smith, 2005: 189). Foucault first wrote about the "medical gaze" in *The Birth of the Clinic* (1973), and later about "docile bodies" in *Discipline and Punish* (1995). Both genealogies deal with disciplinary surveillance: one inside the clinic, the other inside the prison. Although sociologists have largely failed to link surveillance in medicine and penology as Foucault once had, his concept of the "psychiatrisation of criminal danger" (Timmermans & Gabe, 2002: 506) is increasingly relevant today as individuals have become subject to evermore opportunities for surveillance and discipline through health services as well as penal systems. This observation supports both Conrad's and Rose's assertion that, progressively, issues that are considered socially deviant have come under both legal and medical control whereby surveillance is imposed upon the patient so that s/he may be calculated and documented, and institutional action may be taken upon them thereafter (Conrad, 1992: 216; Rose, 1991: 7).

The lives of prisoners proceed through such processes daily, as texts come to demarcate how the prison understands, and thus interacts with the prisoner, enabling her/him to be 'labeled' and 'fit in' to existing institutional categories. Institutional categories may emerge from any one of many prominent discourses: penological, medical, psychopathological, neo-liberal, etc.. From security classification (minimum, medium or maximum), parole boards, or being 'written up' for an incident, prisoners are constantly being 'fit in' in order to be processed in particular ways. For example,

Hannah-Moffat (2004b) argues that many women who “act out” in federal prison often become “diagnosed” with borderline personality disorder. Once such diagnoses are made, they become textually activated; records with this “knowledge” are created, which indicate the authorized interpretation of the individual as “ill” by “projecting” (D. Smith, 2006a: 75) their behaviour as symptomatic. The person then comes to experience a new reality and becomes constituted by this new lens of medical diagnosis.

Diagnosis categories are not arbitrary, however. They are already prescribed according to objectified forms of knowledge and prominent text-based discourses, which then give rise to ruling practices (Campbell & Gregor, 2004: 40) like those of biomedicine. Discourses have productive and generative effects (Carabine, 2001: 268), impacting individuals’ lived subjectivities in an everyday kind of way. But discourses also have destructive effects, by silencing, excluding or omitting ways in which the world can be experienced and understood (D. Smith, 2005: 18). As an empirical goal, textual analysis clarifies how such text-based projections are incorporated into sequences of institutional action (D. Smith, 2006a: 75). This approach is very useful for analyzing discourses that circulate around incarcerated women, as well as those employed in prison policy and mental health services, as they serve to normalize ideas about women’s criminality and mental health, and justify institutional action taken upon them thereafter.

Chapter Three: Methods

Selection of Texts

This research draws upon Dorothy Smith's institutional ethnographic approach by conducting a textual analysis of Correctional Service Canada's policies and practices that coordinate the provision of mental health services to women prisoners. Twelve texts were selected for analysis, each one composing a significant part of the map of institutional relations governing women's prisons. Each text is used to explain part of the puzzle of how things get done in women's federal prisons; specifically, how texts coordinate people's activities, and the ways in which prisoners are understood by CSC. The processes through which these texts 'occur' and 'activate' (D. Smith, 2005; D. Smith, 2006a) the social settings will be plotted and mapped together in order to highlight the CSC's production of knowledge about women prisoners, and to determine the discourses and ideologies by which women inmates are governed.

My data will consist of the most prominent institutional texts that regulate the policies and organization of women's incarceration and provision of health services. These texts not only elucidate the institution's organization, they demonstrate the dominant ideologies and discourses that inform the structure of women's incarceration. The institution's practices are dictated by the underlying medical and penal knowledges that the prison system produces, which are constituted in textual form.

Texts were selected if they played a significant role in coordinating the organization of CSC. The first level of data consists of CSC's governing acts and regulations more broadly, since these policies serve as the fundamental regulations and rules of CSC. All activities within CSC must appeal to these documents, and therefore,

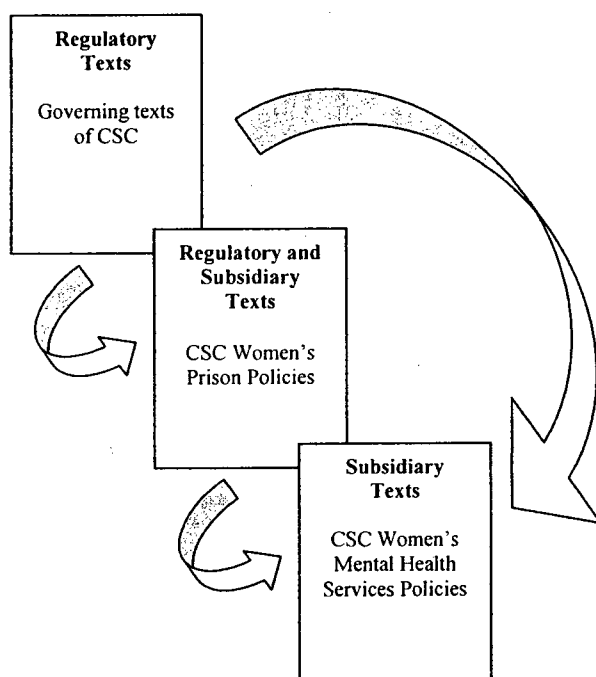
they serve a significant regulatory role within CSC's policies, for both men and women's prisons. These principal texts "regulate" (D. Smith, 2005; D. Smith, 2006a) the interpretation of lower-order, subordinate texts within the intertextual hierarchy. These documents are the *Corrections and Conditional Release Act* (CSC, 1992a) and the *Corrections and Conditional Release Regulations* (CSC, 1992b).

The next level of data is composed of the key documents that outline women's incarceration policy specifically. As stated before, the CSC has drastically modified the organization and practices of women's prisons in the past fifteen years. It has developed what it calls a "woman-centered" prison system, and these texts determine how that system is understood and organized. These texts include the operational plans for women's housing and classification, the CSC's strategies for women's programming, and the seminal report, *Creating Choices* (TFFSW, 1990), which outlines "principles" regarding the treatment of women prisoners that other policy texts frequently claim CSC has adopted. These texts are situated between the "regulatory," "higher-order," or "principal" texts of CSC's governing acts and regulations, and the "lower-order," "subordinate" (D. Smith, 2005; D. Smith, 2006a) texts which specify mental health policy for women inmates specifically. Both this level of data and the higher-order texts inform the interpretation of the following order (see Figure 2 on the following page).

The primary documents which largely define CSC's women's carceral practice are the *Program Strategy for Women Offenders* (Fortin, 2004); the *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004); the *Secure Unit Operational Plan: Intensive Intervention in a Secure Environment* (NIWG, 2003); the *Structured Living Environment Operational Plan* (NIWG, 2002); *Creating Choices: The Report of the Task Force on Federally*

Sentenced Women (TFFSW, 1990); and the *Ten-Year Status Report on Women's Corrections 1996-2006* (CSC, 2006).

Figure 2: Regulatory Direction of the Intertextual Hierarchy



The final level of data is composed of the policies outlining CSC's provision of health services more broadly, and the strategies and policies of women's mental health services specifically. The CSC's recent evaluation of the new mental health services was also included in this group, since it reveals how CSC understands this new era of women's mental health services, and details the 'knowledge' and 'facts' that the CSC has produced regarding women prisoners and their mental health. While the interpretation and regulation of this level of data is facilitated by higher, principal texts, the specific policies of health services may also be used to inform both the ideologies and

contradictions of CSC's institutional practices as a whole. These policies are the *Standards for Health Care* (CSC, 1994); the *2002 Mental Health Strategy for Women Offenders* (Laishes, 2002); the *Evaluation of Psychosocial Rehabilitation within the Women's Structured Living Environments* (Sly & Taylor, 2005); and the *Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment* (Sly & Taylor, 2003)

Mental health services provided to federally incarcerated women are neither consistent nor straightforward. No single document outlines the ways in which mental health services are administered, but, rather, the mandates and practices are described throughout numerous Acts, Strategies and Policies. This research seeks to integrate these documents in order to put together the pieces of the health services puzzle, focusing on the actual operations of CSC's health services. A list of each of the texts and levels of data are provided below, followed by a description of each:

Governing Texts of CSC

- Corrections and Conditional Release Act (CSC, 1992a)
- Corrections and Conditional Release Regulations (CSC, 1992b)

The *Corrections and Conditional Release Act* (CCRA) (CSC, 1992a)—the primary governing policy of CSC—designates the institutional mandate and practices of the CSC through statutes and regulations. It outlines the operation of corrections policy both within prisons and in the community. These policies span the duration of the offender's conviction, from reception and detention, including temporary and permanent release. The CCRA outlines the CSC's general policies regarding inmate programs, health care, and inmate release (temporary, statutory, and paroles). Section III of the

CCRA delineates the role of the Correctional Investigator, including his or her role in the CSC, and his or her relationship to staff, inmates, and other sectors of the government.

The *Corrections and Conditional Release Regulations* (CCRR) (CSC, 1992b) is the complimentary policy document to the CCRA, as it mandates the CSC's specific practices regarding corrections and release. In essence, it directs how the CSC is to 'treat' prisoners through such practices as segregation, search and seizures, use of force, and security classification. Both the CCRA and CCRR contain independent sections on Aboriginal prisoners, and discuss the provision of programs for female inmates.

Women's Incarceration – Strategies, Operation Plans and Principles

There are several documents that outline the policies for women's prisons specifically. The documents included in the analysis outline CSC's policy regarding women's incarceration more broadly, and housing and programming for women inmates:

- Program Strategy for Women Offenders (Fortin, 2004)
- Okimaw Ohci Healing Lodge Operational Plan (CSC, 2004)
- Secure Unit Operational Plan: Intensive Intervention in a Secure Environment (NIWG, 2003)
- Structured Living Environment Operational Plan (NIWG, 2002)
- Creating Choices: The Report of the Task Force on Federally Sentenced Women (TFFSW, 1990)
- Ten-Year Status Report on Women's Corrections 1996-2006 (CSC, 2006)

Women's programming is mandated through one primary policy document, the *Program Strategy for Women Offenders* (Fortin, 2004). It is the most recent publication on this topic. It addresses such programming issues as mental health programs, correctional programs and Aboriginal programs. Policies regarding housing are not concentrated within one document. Women may be housed in Maximum Security Units,

Medium Security Units, Structured Living Environments, or the Okimaw Ohci Healing Lodge. The everyday practices of each of these levels of institutionalization vary, and are outlined within their separate policy documents.

Somewhat distinct from this policy document is the *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004), which outlines the operations of the healing lodge where some women prisoners, primarily Aboriginal, are housed. The Healing Lodge has distinct operational practices, including health service provision, than federal prisons at large. The next two documents govern women's prison structure, the *Secure Unit Operational Plan: Intensive Intervention in a Secure Environment* (NIWG, 2003) and the *Structured Living Environment Operational Plan* (NIWG, 2002), which outline the ways in which women are classified by security level and housed according to their 'mental health.' This includes how prisoners will be provided health services, and which services are available to them. These texts were considered relevant because they mandate the structure and organization of women's incarceration based on their diagnosed mental health status.

The CSC has also published several reports which investigated or responded to ongoing criticisms of women's incarceration practices. These documents seek to 'readjust' the guiding principles through which CSC understands and treats women inmates. The most salient of these is *Creating Choices: The Report of the Task Force on Federally Sentenced Women* (TFFSW, 1990). This report is one of the most significant in the history of criticisms of the CSC's treatment of women prisoners. It was published in 1990 and outlines the historic problems of CSC's treatment of women prisoners, as well as the recommended changes for women's incarceration practices. It was one of the main reports that provoked the restructuring of women's prisons, and the closure of the Prison

for Women. It is frequently cited in CSC's policy documents. More recently, CSC published the *Ten-Year Status Report on Women's Corrections 1996-2006* (CSC, 2006) which outlines the way the CSC understands many of the issues facing women inmates today, including segregation, programming, and housing units. These two texts help illustrate institutional production of 'knowledge' and discourses in regards to women's incarceration, as well as the implicit ideologies at work within their operations.

CSC Health Services

Health Services are loosely discussed throughout many of CSC's documents, including the aforementioned policies. There are also several documents that specifically mandate the policies of health services.

- Standards for Health Care (CSC, 1994)
- 2002 Mental Health Strategy for Women Offenders (Laishes, 2002)
- Evaluation of Psychosocial Rehabilitation within the Women's Structured Living Environments (Sly & Taylor, 2005)
- Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment (Sly & Taylor, 2003)

The *Standards for Health Care* (CSC, 1994) details the provision of health services to both male and female prisoners, while the *2002 Mental Health Strategy for Women Offenders* (Laishes, 2002) outlines how mental health services are provided to female offenders specifically. The CSC's female inmate mental health strategy discusses the types of therapy female prisoners are provided, and the mental health "needs" of the population, as understood by the CSC. The CSC has also published the *Evaluation of Psychosocial Rehabilitation within the Women's Structured Living Environments* (Sly & Taylor, 2005), which discusses the Psychosocial Rehabilitative Program (PSR) for female inmates with "severe psychiatric disabilities." This is a new program implemented to

address female inmates deemed to have serious psychological problems. Likewise, the *Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment* (Sly & Taylor, 2003) discusses the provision of Dialectical Behavioral Therapy (DBT) to women with serious psychological disturbances.

Analytic Strategy

Each text was read and examined comprehensively. Together, they comprised approximately 800 pages of documentation and provided the basis for investigating women's incarceration at the federal level. They outlined the basic governing acts of CSC, as well as women's security classification, housing, and health services more specifically. The body of literature comprehensively details the ruling relations that shape the work of those inside women's federal prisons, and govern federal women prisoners. But they also allow the researcher, through Institutional Ethnography, to analyze the practices, policies and ideologies for what they say about the social world more broadly, and women's place in it.

Both theory and analytic thinking serve as a basis through which data collection is carried out (Campbell & Gregor, 2004). Thus, the selection of data and research questions used to guide the analysis were developed in tandem with theoretical thinking about the puzzle to be mapped through Institutional Ethnography. Once the data had been collected and read, the process of identifying the "problematic" had begun. For institutional ethnographers, the "problematic" (Campbell & Gregor, 2004; D. Smith, 2005) is that which the researcher specifies as the direction of the investigation; the particular "problem" to be solved. While identifying the "problematic" to be explored usually emerges from the specific standpoint of the people inside institutions, in this case,

federally incarcerated women, having no access to women inmates to situate my original direction, the “problematic” of the thesis emerged primarily from research on the criminalization of women, incarcerated women, and mental health issues related to these issues. The theoretical thinking and data analysis were rooted in the theoretical approaches elaborated on in Chapter Two—feminist criminology, sociology of medicine and Institutional Ethnography. Informed by these theoretical approaches, the broader “problematic” that emerged inspired the research questions:

- What can governing texts of Correctional Services Canada indicate about the organization of women’s prisons?
- How do these texts coordinate the practices and day-to-day organization of women’s prisons and health policy?
- At the policy level, to which institutional and medical ideologies and discourses are incarcerated women most subject, and in what ways are such ideologies and discourses applied?

Once the broad problem was identified, it then facilitated a continually nuanced analysis of different levels of textual data as they were read and re-read. The role that each text plays in the organization of women’s prisons is contingent upon where it fits in within the greater organizational scheme of CSC—the intertextual hierarchy. Some texts used in the analysis were seen to express regulatory power over others, while others were seen as subsidiary texts. Different levels of data were “read selectively for different purposes” in order to “find the sense it can make in particular settings of action” (D. Smith, 2006a: 68). Each policy text plays a different role in the map of CSC more broadly, women’s prisons specifically, and the provision of health services therein, and as each text was read and re-read, more specific research questions emerged regarding the different levels of data, each corresponding to, and elaborating on the original “problematic” identified during data collection:

Institutional Organization and Operations

- What are the basic operations and organization of women's incarceration?
- According to the texts, how do people move through the institution?
- How are women classified and housed?
- What do the everyday lives of women prisoners look like when described in these texts?

Mental Health Practices and Organization

- How are health services organized more broadly, and provided to women more specifically, according to these documents?
- How do processes of medicalization come to organize the institution?
- How do texts make medicalization institutionally actionable, or how do they facilitate medicalization?
- Who is provided specific health therapies, and why?
- How are medical labels applied to women in prison?
- Who has the power to medicalize women prisoners, and who does not?
- How do carceral and medical 'knowledge' work in tandem within texts, if at all?

Institutional "Knowledges," Ideology, and Discourse

- What institutional knowledges and discourses are prominent in these texts?
- What would a feminist analysis unearth about the rhetoric and language employed by the CSC?
- How do the CSC's stated principles either compliment or conflict with actual practices?

The analysis of these texts, and the attempt to "solve" the research questions, was informed primarily by the three theoretical frameworks outlined in chapter two. Each perspective contributed its own theoretical tools with which the texts were analyzed, and are evident in the research questions being asked.

The analytic strategy followed the three "tasks" of Institutional Ethnography as articulated by Grahame (1998). Primarily, the texts were read for the ways in which they coordinate institutional practices and shape social relations. The organization of CSC and women's incarceration was first examined, to understand the context within which women's mental health policy is embedded. This task overlaps with an investigation of

the “work” of those within institutions—the second task of Institutional Ethnography. Broader institutional practices—namely housing and security classification—were first plotted on a map of social organization. This map was then expanded to include other levels of CSC structure, including mental health classification procedures. Once these various levels of data were plotted together so that the organization, links, and contexts were highlighted, the analysis could begin to address the ruling relations behind the organization of CSC and women’s mental health policy. The role of people’s “work” in women’s prisons was connected to how the everyday operations and practices of the institution are shaped, and how this textually-mediated process of work sheds light on broader ideologies to which CSC staff and policies appeal.

The final “task” (Grahame, 1998: 353) of the analysis involved linking local social relations within women’s federal prisons with extra-local forces by investigating the institutional discourses and production of “knowledge” throughout CSC’s texts. This level of analysis required an examination of the texts for instances of penal and medical ‘knowledge’ and discourse. Discourses and language that arise most frequently were seen to evidence their significance and power within the institution. This level of analysis included the investigation of institutional “frames” (D. Smith, 2005; D. Smith, 2006a), for example, when women’s actions, mental states and behaviours are defined through medical or pathological discourses in texts, and institutional action is taken upon them in light of this interpretation. Where penal and medical ideologies subsumed or neglected sociological explanations for women prisoners’ behaviours and lived contexts, these were also taken into account. The texts were also investigated for the ways in which the

purported “principles” of the institution contradict actual policies. Contradictions between penal and medical “principles” and actual practices were highlighted.

The “knowledge” and facts produced within these documents were “interrogated” (Campbell, 2003: 6) and subjected to analysis in order to produce an account of the day-to-day practices of the institution (Turner, 2006: 139). This level of analysis will shed light on the invisible ruling relations behind the organization and practices of CSC, as well as how CSC understands women prisoners and their mental health. The analysis is not linear so much as webbed. Texts are connected and linked to one another to form a comprehensible picture of institutional processes and the oft invisible ideologies which structure the organization.

A Word on Limitations

Ideally, a comprehensive Institutional Ethnography of women’s prisons would include multiple sources of data, including interviews with prisoners, medical staff, wardens, direct observation, as well as significant samples of institutional texts. However, such a project is beyond the scope of an M.A. thesis. Although I attempted to include the voices of incarcerated women themselves, I encountered problems accessing prisoner populations. Entering prisons for the purpose of observation, and accessing the myriads of texts that shape the day-to-day processes of prison life and health services is beyond my reach. My methods are, in no small way, limited by these restrictions. Thus, I have had to limit my own methodology to the textual analytical element of Institutional Ethnography. While this limitation offers the advantage of facilitating detailed attention and focus to the complexity of institutional documents, it nonetheless results in disadvantages in the research. It is unfortunate, that as a feminist researcher, I was unable

to include the voices of women prisoners themselves. For two years I tried to acquire the support I believed was needed to contact women who had served time in federal prisons. Thankfully, I was made aware of potential problems with such an objective; namely, that many federal women prisoners have been so wronged by institutions that they are, understandably, suspicious of and reluctant to comply with people representing institutions, including universities. Undoubtedly, this omission may leave my research vulnerable to serious critique. I believe it is necessary to note that the lack of representation of federally incarcerated women in this research is regrettable, and that my own privilege as a middle-class white woman who has never been in conflict with the law is likely to cause shortsightedness in some areas.

Another significant limitation is that textual analysis is meant to be complimented by a component of analysis which addresses the “everyday lives and practices” of people—both those working within institutions, as well as those within the institutional system, such as prisoners or patients. This materialist analysis allows the researcher to account for individuals’ presence within institutions “for her knowing and doing” (Campbell, 2003: 12). Although the value and relevance of mapping institutional texts on their own should already be clear, it is much more difficult to bridge the gap between the textual world, and “how things really happen” without further supplemental research. What becomes more difficult, then, is drawing generalizations about the “local sites of experience” (D. Smith, 1999: 130) of women prisoners. This is not to say that textual analyses cannot provide a sociological map about the conditions in women’s prisons; to the contrary, Smith reminds us that it is the institution’s processes which are the subject of inquiry, rather than the experience of those within it (2005: 38). Texts are understood

to 'activate' social settings, and are therefore integral to understanding what is 'actually happening' inside institutions. This limitation can only be addressed through the recognition that a textual analysis can only tell us so much about the lived actualities of women prisoners' lives, and that the line between my own "subjective interpretations and assumptions" and the "objective and material truth" is sometimes ambiguous.

Chapter Four: 'Mapping' the Local Site of the CSC

Textual Coordination

This chapter serves as the departure point of the institutional 'map' of women's federal prisons. The primary goal is to establish and plot the organizational structure of CSC, locating women's mental health services within it. I narrate the map through the intertextual hierarchy of the textual data beginning with the broad governing documents of CSC—its legislation and regulations as an institution—then move through women's federal prison policy specifically, which is embedded within the broader governing policies of CSC. Finally, I discuss health services for women, which are embedded within women's prison policy and then CSC's legislation and regulations more generally. This map will serve as the foundation of the following chapter, in which I begin to identify the institutional discourses and ruling relations of CSC. It then becomes possible to expose links throughout these various levels of data, and identify the power relations that inform the organization and policies of CSC, yet are otherwise obscured by the appearance of institutional objectivity.

According to Smith's methodology, incorporating texts into an institutional ethnography has two fundamental stages. Firstly, texts must be understood as "active" and "occurring," (2005: 180, 2006: 86); and secondly, texts must be explored, or mapped, for how they are embedded in and "coordinate institutional courses of action" (Smith, 2005: 86). The activity of all individuals within the institution is coordinated through this process—both institutional staff as well as those subject to the institution (Smith, 2005: 183). Texts bind people together by shaping the ways in which individuals, unknowingly, relate and behave in concert with one another to serve the goals of the institution

(Campbell & Gregor, 2004: 32). Adopting Smith's observation that texts operate through "intertextual hierarchy" (2005: 187)—that is, they are organized hierarchically in their relation to one another—I begin the analysis with the "higher order" texts. These "regulate" the "subordinate" texts by providing the fundamental discourses, concepts, and methods that are used to activate and understand them (ibid.).

Following Smith, my analysis investigates the ways in which power can be revealed through texts for the ways in which it constitutes subjects and establishes their agency (D. Smith, 2005: 183). Once the coordinating activity of texts is mapped throughout this chapter, it then "becomes possible to trace connections that might otherwise be inaccessible...the organization of powers generated in the ruling relations" (D. Smith, 2005: 181), which I do in chapter five. I will then identify ruling practices as they emerge from text-based discourses and objectified forms of knowledge (Campbell & Gregor, 2004: 40).

Legislation and Regulations

In order to begin mapping the organization and policies of CSC, one must begin with its primary governing acts and regulations—the highest order texts in the intertextual hierarchy. The *Corrections and Conditional Release Act* (CCRA) (CSC, 1992a), and the *Corrections and Conditional Release Regulations* (CCRR) (CSC, 1992b) provide the wider context within which all other correctional policy is embedded. The CCRA and CCRR outline the fundamental mandate of CSC, and situate the guidelines of its correction policy within that mandate. These documents are "higher-order" texts (D. Smith, 2006a: 87), to which all other policy must appeal, and are frequently cited throughout CSC's reports, strategies, and policies.

Importantly, the CCRA describes the “purpose” and “principles” of the correctional system. These include the “maintenance of a just, peaceful and safe society” through overseeing corrections and “rehabilitating” inmates (CSC, 1992a: n.p.). The “principles” of CSC state that “the protection of society be the paramount consideration in the corrections process,” indicating that, from the outset, this concern is privileged over the protection of inmates confined in the correctional system. However, the texts articulate numerous principles which are presumably meant to protect the safety and rights of prisoners. The CCRA mandates that the CSC “use the least restrictive measures consistent with the protection of the public, staff members and offenders” to detain inmates (*ibid.*), section 69 prohibits “cruel, inhumane or degrading treatment or punishment” of prisoners (CSC, 1992a: n.p.), and section 83 of the CCRR guarantees that prisons are safe and “healthful” (1992a: n.p.). If prisoners are to be strip-searched, they are guaranteed the right to be searched by a staff member of the same sex (CSC, 1992a, 1992b), although there is no mention of how this policy is applied to transsexual prisoners, either pre- or post-operation³. Such policies indicate that the CSC is mandated to consider the well-being of prisoners, even if it’s not CSC’s paramount objective, by prohibiting excessive restriction and degrading treatment of prisoners, and by ensuring their health and safety.

The CCRA and CCRR also suggest, at the most broad policy level, that the CSC has attempted to resolve discrimination against particular groups of prisoners—specifically, women, Aboriginals, and persons with disabilities. Prisoners with disabilities who are unable to earn a wage participating in work programs are “compensated”

³ CSC’s policy regarding the treatment of transsexuals inmates, Commissioner’s Directive 800 (Coulter, 2008), also fails to clarify how strip-searches shall be imposed on transsexual prisoners.

financially, although no more than “75 per cent of the monthly minimum wage” (CSC, 1992b). Section 83 of the CCRA guarantees Aboriginal spiritual leaders the same religious status as other religious leaders. However, it does not guarantee Aboriginal inmates *access* to such spiritual leadership, but rather states that it “shall take all reasonable steps to make available to Aboriginal inmates the services of an Aboriginal spiritual leader or elder” (CSC, 1992a: n.p.). CSC also states that inmates may be considered for release into “the care and custody of an Aboriginal community” (CSC, 1992a, 1992b) should an inmate make such a request. An Aboriginal advisory committee and “appropriate” women’s groups are to be consulted regarding Aboriginal and women’s incarceration, according to the CCRA (section 82(2) and 77(b)), although it fails to define how the institution qualifies “appropriate.” These clauses indicate that the CCRA and CCRR mandate some measures which would presumably ensure that the rights of Aboriginal, female and disabled prisoners are respected, especially through the development of an Aboriginal Advisory Committee, and liaisons with “appropriate” women’s groups. While such policies should have significance for the organization of CSC, however, we will see later that CSC’s practical achievement of these mandates is debatable.

The CCRA and CCRR also outline CSC’s policy regarding the disciplining of prisoners in sections 38 to 44 of the CCRA and sections 24 to 41 in the CCRR. These sections are significant because they objectify CSC’s concept of “discipline,” and sanction the situations in which discipline is justifiably used by stating that “inmates shall not be disciplined otherwise than in accordance with sections 40 to 44 and the regulations” (CSC, 1992a: n.p.). Thus, it is important to note that the CCRA only

includes the specific disciplinary offences (contained in section 40 of the CCRA), and the specific disciplinary sanctions (contained in section 44 of the CCRA) taken upon prisoners thereafter in their institutional definition of “discipline.” As a result, these sections determine how “discipline” is understood by CSC, omitting any other possible definition of “discipline” from its policy. The implications of this limited definition of “discipline” will be elaborated on later.

Policy on Inmate Health

Inmate health figures prominently in the policies defined in the CCRA and CCRR. According to the CCRA, the CSC is obligated to provide inmates with “essential” health care and “non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community” (CSC, 1992a: n.p.). However, the CCRA does not define what actually constitutes “essential” health care, or what types of mental health services will contribute to rehabilitation. The *Standards for Health Care* (CSC, 1994) is the fundamental policy articulating the guidelines for the provision of health care, and this policy defines what “essential” *physical* health services involve, including dental, urgent, or emergency health care. However, its delineation of “essential” *mental* health services is more ambiguous:

Essential health services shall include...mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life. This includes the provision of both acute and long-term mental health care services (CSC, 1994: 12).

The policy’s description of behaviours which elicit mental health services is problematic on a number of levels. Mental health is a complex issue, and language such

as “disturbances” and “impaired judgement” do little to clarify how mental health is understood by the CSC. What may be interpreted as ‘disturbed behaviour’ by prison staff may be interpreted by others as a rational and sane response to distressing circumstances. CSC does not qualify what constitutes “serious mental illness,” or to whom CSC appeals for this definition whether it be CSC’s psychiatric staff, the *Diagnostic and Statistical Manual* (APA, 1994), or something else entirely. Rather, this policy employs a problematic logic by qualifying what constitutes “serious mental illness” solely through the behaviours for which mental health services are to be administered, without an independent definition of “mental illness.” Therefore, this policy, which serves as the foundational statute on the delivery of all mental health services throughout CSC, only delineates what constitutes mental health services by stating that such services are offered to individuals with “serious mental illness”: a vague and broad collection of behaviours and mental states. This list of “symptomology” provides some of the fundamental “frames” (D. Smith, 2006a) through which prisoners will be interpreted by staff and processed through the institution.

Moreover, the established function of essential mental health services is not framed as ‘therapeutic’ according to this policy, but rather, framed as a ‘response’ that CSC may make towards inmates whose behaviours are seen as symptomatic or unmanageable. This mandate, then, not only fails to clarify what constitutes essential mental health services, but it permits CSC to cast a wide net over what behaviours warrant medical intervention. This regulatory policy grants CSC staff with great power and authority to widely interpret behaviours as “symptomatic,” “disordered” or “impaired” without appealing to a clear or standard guideline for such interpretation, and,

as we will see later in this chapter, establishes opportunities for prisoners to be medicalized in broad contexts by employing such pathologizing frames. Frames play a significant role in how institutions produce ‘knowledge’ about inmates by determining how the institution interprets individuals and how they are objectified in institutional records and documents (D. Smith, 2005: 191). How these frames ‘occur’ and operate in practice will become clearer as subordinate texts are explored throughout this chapter.

The first opportunity for this ambiguous definition of ‘health’ to be applied to prisoners is immediately upon their intake into the prison. According to Health Standard 201 of *The Standards for Health Care*, prisoners are screened and assessed upon their arrival to determine their health status (CSC, 1994: 10). This moment is crucial for prisoners, as it will determine how the prison will define him or her medically from that point forth⁴. A staggering 25% of all women prisoners are diagnosed with some variety of mental disturbance upon intake into CSC—twice the rate of male prisoners (CSC, 2006: 40, 2007a: 4). While the CSC assumes that this is a reflection of the ‘reality’ of mental disturbances that incarcerated women possess, this rate of mental illness diagnosis more accurately reflects the frequency with which CSC *diagnoses* women prisoners with mental illnesses.

The intake mental health screenings are only the initial context within which CSC may refer prisoners to mental health services. *The Standards for Health Care*, a subordinate policy text to the CCRA and CCRR, also states that CSC may provide “an appropriate clinical response to inmates exhibiting signs of serious mental illness” (CSC,

⁴ The CSC is currently piloting a project that would have prisoners assessed for mental health problems upon intake by a 30 to 40 minute computerized survey (CSC, 2007b: 6). Such an initiative lends evidence to Dorothy Smith’s claim that institutional discourses are increasingly quantified through “technologically refined sets of questions or ratings” (D. Smith, 2005: 191).

1994: 19) at any time. If a prisoner is deemed to be presenting signs of mental illness by prison staff, he or she is to be placed under close observation by “trained staff” until an “appropriate clinician” can be consulted (ibid.). It is important to note that under Standard 503 of CSC’s health standards (CSC, 1994: 26), all staff members who work with inmates are considered qualified to make such an assessment of prisoners’ mental health. Staff are trained to both assist in medical emergencies (through first aid and CPR), as well as “to recognize and refer those with significant behavioral changes or signs of mental health difficulties” (ibid.). Importantly, then, all CSC staff are granted the authority to assess prisoners’ behaviours and mental states as pathological. As Zimmerman noted, institutions generate facts through the observation, supervision and surveillance of individuals so that their activity can be known, managed and documented. Staff may be compelled to observe people’s activities within the institution in order to ensure they are adequately coordinated with the goals of the institution (Zimmerman, 1975: 130). Arguably then, this policy affords all staff the power to exercise penal and medical control over prisoners by subjecting them to surveillance, medicalization and/or pathologization in order to accomplish the goals of the institution. As we will see later in this chapter, CSC’s policy documents on women’s mental health services, which are embedded within the broader institutional context of higher-order texts such the CSC’s generalized *Standards for Health Care*, draw upon this policy in problematic ways.

Although *The Standards for Health Care* clearly prioritizes a western bio-medical definition of ‘health,’ it asserts that CSC integrates a “holistic” and “multidisciplinary” approach to its “essential” health services (CSC, 1994: 3). However, CSC’s health standards fail to qualify what such an approach might include. In fact, there is no policy

that specifically defines and mandates the use of holistic medicine⁵. It is not clear whether CSC is referring to such things as homeopathy or naturopathy, or whether it is referring to “holistic” approaches within a western-bio-medical doctrine such as pharmacological treatments and geneticization, which are both ‘alternative’ approaches that can be pursued within western medicine’s current paradigm (Lippman, 1991: 19).

The CSC rightfully prohibits the prescription of pharmaceuticals for “disciplinary or control purposes” (CSC, 1994: 24) (an admission that such a practice is possible). But some have argued that pharmaceuticals inherently serve a social control function (Conrad, 1992: 216). There are no objective criteria of what constitutes “essential” pharmaceutical use, or what “holistic” alternatives could be more effective. In fact, psychiatric practices, whether they be illness categorization, diagnoses, or pharmacological treatment, involve social-defined criteria of “normality” (Conrad, 1992; Reuter, 2007: 84; Scott, 2006; Wright & Treacher, 1982), and thus any claim to their being objectively “essential” is questionable. However, it has been suggested that there may be consequences for women who resist pharmacological treatment. CSC staff may identify those who refuse pharmaceuticals as “difficult to manage...unpredictable, and...more prone to ‘acting out’” (Hannah-Moffat & Shaw, 2001: 51) or use their refusal as a justification for a disciplinary charge (ibid.). This indicates that in fact, CSC may use pharmaceuticals in disciplinary ways, or to control inmates, despite that this practice is prohibited according to the *Standards for Health Care*.

There are several aspects of CSC’s health policy regulations that appear to be in the interests of protecting prisoners’ mental health that may be similarly problematized.

⁵ According to CSC National Pharmacist, Craig Shankar, as indicated in a personal email to me sent March 18th, 2008.

Prisoners' mental health must be considered in numerous decisions made by CSC. Clause 87 of *The Corrections and Conditional Release Act* (CSC, 1992a) is greatly significant to the structure of women's incarceration. It states, seemingly benignly, that the CSC "shall take into consideration an offender's state of health and health care needs...in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters" (1992a: n.p.). Similarly, the CSC must take prisoners' mental and physical health into account when determining their security classification (1992b: n.p.). It states:

The Service shall take the following factors into consideration in determining the security classification to be assigned to an inmate pursuant to section 30 of the Act: any physical or mental illness or disorder suffered by the inmate. (ibid.)

These clauses appear to be in the interests of the prisoners, because they imply that prisoners' health must be considered in order to protect them from being placed in a security classification or segregation if it would further harm their state of health.

Problematically, the CCRR does not actually specify how these factors mediate classification specifically, rather it simply states that they should be considered, and rightfully so. Inmates who exhibit psychological distress should be exempted from receiving Maximum Security classification, or being placed in segregation given that these environments involve greater levels of restriction, control, isolation, strict and regimented routines, and disciplinary responses by prison staff, all of which can exacerbate psychological distress. However, as we will see in policies objectified in subordinate policy texts, women's mental health problems are more often used to justify higher security classification and more frequent committal to segregation.

The provision of health services may be further problematized when it comes to the medical standards of voluntary informed consent and the right to refuse treatments. The *Corrections and Conditional Release Act*, CSC's most significant governing policy, declares that "treatment shall not be given to an inmate, or continued once started, unless the inmate voluntarily gives an informed consent thereto" (CSC, 1992a: n.p.). This standard is then further elaborated in many subordinate mental health policy texts including the *Standards for Health Care* (CSC, 1994), the *Structured Living Environment Operation Plan* (NIWG, 2002), and *The 2002 Mental Health Strategy for Women Offenders* (Laishes, 2002), to name a few. Similarly, it is often cited within CSC health documents that prisoners have the right to refuse any health services offered them (CSC, 1994; Laishes, 2002; NIWG, 2002; Sly & Taylor, 2003, 2005). However, there are clearly exceptions to this rule. Although the principles of informed consent and the right to refuse treatment are both defined in the *Standards for Health Care* (CSC, 1994), it also includes an 'Involuntary Treatment' clause without clarifying the circumstances under which this type of treatment is provided (CSC, 1994: 6). Despite that voluntary informed consent is repeatedly emphasized as mandatory for health services to be administered, the CCRA goes on to declare that "an inmate's consent to treatment shall not be considered involuntary merely because the treatment is a requirement for a temporary absence, work release or parole" (CSC, 1992a: n.p.). Said another way, voluntary consent *is not mandatory* when prisoners are expected to receive treatment in order to acquire release or parole. Considering parole and release are the quintessential 'goals' of prisoners, such a regulation may leave prisoners vulnerable to being coerced into treatments that are deemed mandatory in order for parole or release to be permitted. However, nowhere was

it found that the CSC acknowledged this as a possibility, or took measures to address it. In light of the fact that the CSC goes to great lengths to stress and define the standard of *informed consent* and the *right to refuse treatment* throughout their health policy documents, it is a noticeable omission that the circumstances under which involuntary treatments are applied do not deserve the same consideration. CSC's inclusion of the definition of informed consent and the right to refuse treatment, to the exclusion of a definition for involuntary treatment, projects an image of upholding a high standard of medical ethics while leaving room for the eschewal of those very standards. Only in one instance, contained in *The Standards for Health Care*, does CSC state that inmates may be "committed" to institutions with more extensive psychiatric services (CSC, 1994: 19). However, it is not clear how often CSC imposes "involuntary treatments" or "commitments" on prisoners, since "CSC does not collect statistics about frequency of involuntary treatment"⁶. As we will see in chapter five, these 'oversights' have serious and significant implications for how mental health services are administered to federally sentenced women.

This section has begun the process of "mapping" (D. Smith, 2005) the CSC through some of the salient principles and policies outlined in CSC's "higher-order" (D. Smith, 2006a) policy regulations, the CCRA and the CCRR, situating CSC's fundamental health services policy, the *Standards for Health Care*, within the map. These regulatory texts express the fundamental "principles" and goals of the institutions, and set forth the guiding frames of how all prisoners are to be understood and treated. While the CCRA and CCRR regulate subsidiary policies such as CSC's *Standards for Health Care*, the

⁶ This quote was taken from an email sent to me by CSC's National Pharmacist, Craig Shankar, March 18th, 2008, upon my inquiry into the conditions under which "Involuntary Treatments" are administered, and the frequency with which this practice is exercised.

Standards themselves serve to regulate other subordinate texts as well. The frames employed by CSC within these texts play a significant role in subsequent policy documents—the “lower-order” texts in the intertextual hierarchy—such as women’s prison policy and the health services therein.

It is within this primary level of data that the “problematic” has begun to be explored. Some of CSC’s governing principles and practices, such as least restrictive measures, involuntary informed consent, disciplinary actions, Aboriginal programming, and essential mental health services, have been problematized, and placed on a map of CSC’s institutional organization. These practices will be further problematized through their elucidation in the lower levels of data, the subsidiary texts governing women’s prison policy specifically, and the mental health services therein. The organization of women’s prisons will now be explored and mapped by making links between these various levels of data.

Organization of Women’s Prisons and Mental Health Services

Creating Choices

Creating Choices (1990), conducted by the Task Force on Federally Sentenced Women (TFFSW), is one of the most notable investigations of the CSC in the last few decades because it was one of the first reports which emphasized that CSC policy must consider men and women inmates differently, and called for reforms to put this into practice. The report had a significant effect on the eventual restructuring of women’s federal incarceration, and the CSC has since proclaimed to have created “gender-sensitive” practices by adopting the report’s principles. *Creating Choices* emphasized

some of the greatest issues women faced in the P4W, from poor or inadequate programming (such as employment programming that included beauty parlour classes), to lack of child care facilities (TFFSW, 1990). Other problems included geographic dislocation, and prisoners being coerced to submit to psychiatric services (ibid). Furthermore, it noted the decrepit state of P4W, which was so severe, it was eventually declared “unfit” to house human beings.

The report also addressed some of the structural and systematic discrimination of women within federal institutions. One of the most notable problems was that the facility and programming were designed for men. Correctional philosophy, it argued, was developed within a “White male context” (TFFSW, 1990: n.p.), yet applied to all inmates regardless of gender or ethnicity. Many Aboriginal women complained of experiencing violent racism. They expressed frustration towards racist attitudes by prison staff, who labeled them “violent” and unruly. The CSC would not recognize the unique experiences and situations of Aboriginal women, which served to both divide them from their traditional culture and blame them for their own circumstances (ibid.).

The report recommended several “principles” upon which the CSC should operate to combat its male normative structure and systemic racism. The principles included: Empowerment, Choice, Respect and Dignity, Support, and Shared Responsibility (TFFSW, 1990). These principles were meant to be the basis of the reorganization of women’s federal imprisonment to a new, “empowering” model of female corrections, from housing and security classification, to programming and health services. The extent to which CSC has implemented these principles, however, or the possibility of

implementing such principles in a carceral context at all, will be addressed in chapter five.

Housing and Security Classification

The organization of women's federal institutions is based primarily around security classification and mental health status. Between 1995 and 1997, women prisoners were moved from the P4W and transferred to regional prisons with apartment-style housing that hold up to 10 individuals (CSC, 2006; NIWG, 2002). These houses were developed to hold Minimum and Medium Security women prisoners who had previously been held in Maximum Security conditions within the P4W. Minimum Security prisoners compose approximately 35% of CSC's women population while Medium Security prisoners compose approximately 45% of the women's population (CSC, 2006: 27). Thus, the vast majority of women inmates live amongst a small group of inmates together with whom they share responsibility for the daily maintenance of their 'home' (ibid.). A small proportion of the population is housed either in the Regional Psychiatric Center in Saskatoon or the Institut Philippe Pinel de Montréal. Finally, ten percent of women are classified as Maximum Security (including all women sentenced to life, who must spend at least two years of their sentence in Maximum Security). The organization of Maximum Security housing is somewhat more complicated than that of Minimum or Medium Security. Maximum Security inmates are housed in 'Secure Units' which are more like traditional cells, and are subject to much more intervention and supervision by prison staff (CSC, 2006: 28). Finally, a small proportion of the federal women's population—roughly 25 prisoners—is housed in the Okimaw Ohci Healing Lodge.

The Okimaw Ohci Healing Lodge was developed for Aboriginal prisoners, located on Nekaneet First Nation land near Maple Creek, Saskatchewan. According to the *Okimaw Ohci Healing Lodge Operation Plan*, the Lodge offers “dynamic” and “static” security measures that foster “constructive relationships” while facilitating secure management of prisoners, rather than containing women through traditional security measures such as barbed-wire fences (CSC, 2004). Instead of traditional prison guards and wardens, the *Lodge Plan* states that the CSC will recruit Aboriginal community members as staff at the lodge, although it has been argued that few Aboriginal people, including Nekaneet community members, actually hold senior positions (Monture-Angus, 2002: 18).

The *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004) refers to higher-order policy texts—including the *Corrections and Conditional Release Act* (CSC, 1992a), *Creating Choices* (TFFSW, 1990), the *Program Strategy for Women Offenders* (Fortin, 2004), and the *2002 Mental Health Strategy for Women Offenders* (Laishes, 2002)—as the basic policy texts governing the mandate and organization of the lodge. Importantly, the Plan refers to several “empowering” and progressive principles as the basis through which the Lodge was developed. According to the *Lodge Plan*, the role of the lodge is to provide a “safe and empowering environment...free of racism and sexism” for inmates through five principles of healing—Restoring pride and dignity as women and mothers; Restoring a sense of dignity, worth, and hope within Aboriginal communities; Rebuilding Aboriginal families and communities; Building connections between Aboriginal and non-Aboriginal communities; and Promoting the healing of the earth (CSC, 2004: n.p.). The *Lodge Plan* further reiterates the foundational principles of women’s prison policy

outlined in both *Creating Choices* (Empowerment, Responsible Choices, Respect and Dignity, Supportive Environment, and Shared Responsibility), and those stated in the *2002 Mental Health Strategy for Women Offenders* (Wellness, Access, Women-Centered, Client Participation, and Least Restrictive Intervention) (ibid.). Minimum and Medium Security-classified Aboriginal women are given priority access to the Healing Lodge, regardless of their mental health status, while Maximum Security prisoners are not eligible to be housed at the Lodge.

Although mental health does not organize if and how women are housed in the Okimaw Ohci Healing Lodge, it plays a significant role in the organization of traditional women's prisons. While most Minimum and Medium Security women are placed in "apartment-style" housing, all women inmates deemed to be "higher-need, higher-risk women or those with severe mental health problems" (NIWG, 2002: n.p.) are subject to the *Intensive Intervention Strategy*. The strategy is implemented in two parts: the first part is for Minimum and Medium Security women outlined in the *Structured Living Environment Operation Plan* (NIWG, 2002), the other is a separate model for Maximum Security women outlined in the *Secure Unit Operational Plan* (NIWG, 2003).

Maximum Security women who are placed under the *Intensive Intervention Strategy* are understood by CSC to possess "anti-social behaviour," "criminal attitudes" or "emotional/mental health issues" (NIWG, 2003: n.p.). They are segregated from the rest of the population in the institution, and their movement throughout the institution is surveilled. It involves the accompaniment by one or more staff at the least, and physical body restraints such as handcuffs, body belts, or leg irons at the most (NIWG, 2003: n.p.). Other restrictions imposed upon Maximum Security women include rules against

visiting other women in their unit, and restricted access to the library, gymnasium, and the visitation area for family or friends (NIWG, 2003). Furthermore, Maximum Security women are frequently placed in involuntary segregation. Within a one year period, almost three quarters had been placed in segregation against their will, while half of the Maximum Security women had gone into segregation voluntarily (NIWG, 2003: n.p.).

Access to the prison is scheduled so that they will not have contact with other women prisoners. This restricted access to the prison impacts how they are provided health services. The *Secure Unit Operational Plan* states:

...[C]ertain interventions will require that the women visit the Health Services Centre. Except in emergency cases, these visits will be scheduled to limit contact with the main population and women will be under staff supervision. Medical information is confidential, and the escorting officers — must respect this information. The risk assessment can determine whether the Primary Worker must remain in the room with the inmate, though some practitioners may insist that the security staff remain (NIWG, 2003: n.p.).

Such a policy, then, creates barriers to Maximum Security women accessing health services easily in order to avoid their contact with the general prison population. Moreover, this policy indicates that they are not, in fact, provided medical confidentiality, despite that confidentiality is one of the fundamental “principles governing the management and delivery of health services” according to the *Standards for Health Care* (CSC, 1994: 3). The presence of staff during medical interventions eliminates the possibility of confidentiality, even if escorting officers are expected to “respect” (NIWG, 2003: n.p.) medical information they have witnessed. This practice may be particularly invasive for those receiving pap smears, having their STI status disclosed, and may be particularly violating for transsexual inmates. Moreover, if a prisoner has an antagonistic relationship with those who are surveilling her medical appointments, the prisoner does

not have access to a confidential environment where she may feel open to express her concerns with a doctor. This may be particularly problematic for those who engage in acts of self-harm, drug use, sex, or other activities prison that may result in disciplinary consequences.

Clearly, there exists a great deal of physical and mobile restrictions on women in the 'Secure Units' who are being provided the Intensive Intervention Strategy. Since women are provided this Strategy if they are deemed to possess significant "emotional/mental health issues" (NIWG, 2003: n.p.), they should presumably be the same demographic of prisoners intended to be protected by some of the regulations laid out in the CCRA and CCRR. It appears, however, that CSC's treatment of this population is exempt from some of the protections mandated in the CCRA, CCRR, and the *Standards for Health Care*, such as medical confidentiality. More worrisome is the failure to employ the protections intended for prisoners with mental health needs. While clause 87 of the CCRA states that the CSC "shall take into consideration an offender's state of health and health care needs...in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters" (1992a: n.p.), it is clear that Maximum Security prisoners are subject to greater disciplinary restrictions and management, despite that they are considered to have significant mental health needs. It is not only arguable whether the CSC is making the appropriate "consideration" intended in clause 87 of the CCRA, it is clear that the CSC has not respected the implementation of the "least restrictive measures consistent with the protection of...offenders" (CSC, 1992a: n.p.) when it comes to this particularly vulnerable population. Women subjected to the Intensive Intervention Strategy in Secure

Units have restricted access to institutional space, restricted opportunities for medical confidentiality, and restricted freedom to visit friends, family and other inmates. Perhaps more blatantly restrictive is the use of bodily restrictions such as handcuffs, body belts and leg irons on this population, and the frequency with which they are committed to segregation.

While the policy behind the *Intensive Intervention Strategy* for the ‘secure environment’ emphasizes the necessity to restrict Maximum Security prisoners’ freedoms, the *Intensive Intervention Strategy* policy for the ‘Structured Living Environment’ (SLE), in contrast, emphasizes the freedom with which Minimum and Medium Security women can access the institution. It states,

A woman in the SLE has access to and is encouraged to use the programs and physical spaces available in the rest of the facility including health care, the gym, private family visit house, visiting area, programs, work sites, social activities and crafts (NIWG, 2002: n.p.).

Given that Maximum Security women are subject to the *Intensive Intervention Strategy* in a ‘secure environment,’ it is unsurprising that they face greater restrictions on their access to institutional programs and services than Minimum and Medium Security prisoners. However, Minimum and Medium Security women—those subject to the *Intensive Intervention Strategy* in a ‘Structured Living Environment’—face problems of their own despite lesser restrictions and security measures. Significantly, the structured living environments do not make room for children, thus exempting women in the SLEs from Mother-Child programs (NIWG, 2002: n.p.). Although the lack of facilities for children is mentioned only briefly within the *Intensive Intervention Strategy - Structured Living Environment Operation Plan*, the impact of this significant oversight may not only be detrimental to mothers living in the SLEs, but to their children as well. The fact that

this issue garnered so little attention in any of CSC's women's policy texts is a serious concern.

If participation in the SLEs comes at the cost of contact with children, consent to this 'treatment' is a significant matter, and the policy text of the SLE rightly emphasizes the significance of informed voluntary consent (NIWG, 2002: n.p.). The *Intensive Intervention Strategy* references other health policy documents stating that voluntary consent is mandatory for all health treatments offered to women inmates, and that prisoners have the right to refuse treatments or cease treatment regimes at any time⁷ (NIWG, 2002: n.p.). While this is a noble goal for the Strategy, and nothing less than a basic standard of medical practice that should be afforded all patients, voluntary consent is not provided by all women in practice. In CSC's evaluation of Dialectical Behavioral Therapy (DBT) and Psychosocial Rehabilitation (PSR)—treatments which are provided to women living in the SLEs—almost a third of women surveyed reported that they felt “coerced” into entering the SLEs (Sly & Taylor, 2003: 10, 2005: i). Although CSC's evaluations of DBT and PSR emphasized the positive outcome of these treatments, the considerable percentage of women who were coerced into entering the SLEs is no insignificant matter.

It is clear that there are significant problems with many of CSC's new classification and housing programs regardless of whether women are housed in the Secure Units, the SLEs, or the Okimaw Ohci Healing Lodge. The issues that women face regarding housing and classification are highly correlated with mental health services

⁷ The Intensive Intervention Strategy is both a housing system as well as a therapeutic program for both the Secure Units (Maximum Security inmates) and the SLEs (Minimum and Medium Security inmates). The problems associated with the IIS as a therapeutic model will be explored in greater detail in the following section.

because mental health status can determine the ways in which they are classified and housed, and because this classification then determines which mental health services are provided to them. While this section has explored the policies outlining women's housing and classification as they are embedded and linked to CSC's wider governing policies, they must also be situated and contextualized by the specific mental health services provided in women's prisons.

Women's Health Policy and Mental Health Services

Not surprisingly, prisoner health (especially mental health) is central to governing texts of the CSC, as health is considered one of the basic criteria of an individual's well-being. Through such reports as *Creating Choices* (TFFSW, 1990) the CSC has begun to acknowledge the social nature of mental health practice (and mental health status). In general, women prisoners reported to the Task Force on Federally Sentenced Women that they required greater choice and control over health care decisions (TFFSW, 1990: n.p.). Since the publication of *Creating Choices*, numerous criticisms of CSC's health policy have reiterated that services in the P4W were male-normative and inappropriate for women prisoners. These criticisms motivated the CSC to develop a separate mental health policy and program for women prisoners, primarily implemented over the last three to ten years. Throughout many of their women's health policy texts, CSC has promoted their new women's mental health practices as the paragon of gender-sensitive carceral policy.

Although women are subject to the same health service policies as men outlined in *Standards for Health Care* (CSC, 1994), there are several subordinate texts which outline CSC's women's mental health policy specifically. These are the 2002 *Mental*

Health Strategy for Women Offenders (Laishes, 2002), the *Program Strategy for Women Offenders* (Fortin, 2004), and the *Intensive Intervention Strategy* (NIWG, 2002, 2003).

Two of the major mental health services provided to women prisoners, Dialectical Behavioural Therapy (DBT) and Psychosocial Rehabilitation (PSR), are further discussed in the *Preliminary Evaluation of Dialectical Behavior Therapy Within a Women's Structured Living Environment* (Sly & Taylor, 2003) and the *Evaluation of Psychosocial Rehabilitation Within the Women's Structured Living Environments* (Sly & Taylor, 2005). Those housed at the Okimaw Ohci Healing Lodge are subject to a combination of these policies, along with a somewhat distinct health service philosophy as detailed in the *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004).

The 2002 *Mental Health Strategy for Women Offenders* (Laishes, 2002), the — fundamental policy document detailing women's mental health services, outlines the principles of women's mental health programming. The document states that five principles form the basis for the development and provision of mental health services for women. These principles are: Wellness, Access, Woman-Centeredness, Client Participation, and Least Restrictive Measures (ibid.). The principles of Access and Least Restrictive Measures both reference the CCRA (CSC, 1992a), wherein these principles were first declared.

The *Mental Health Strategy* details how mental health services are organized and administered to women prisoners. Services are provided based on the CSC's "Continuum of Care" model (Figure 3, p. 98) (Laishes, 2002, Appendix L: 24), which is a complex

and multi-leveled organization of health care provision⁸. The first level of “The Continuum of Care” is the initial health assessment for all prisoners upon entry into prison. As stated earlier, this is an essential moment of classification for women prisoners because the assessment is meant to determine their mental health needs in order to produce a “single, comprehensive treatment plan,” which is determined by “the level and intensity of mental health intervention required, as well as the women’s willingness to participate in various forms of treatment” (Laishes, 2002: 20). This medical assessment of women prisoners is one of the most significant institutional practices of the CSC, as it determines, from that point forth, the institutional classifications to which she will be ‘fit in,’ whether they be her medical diagnoses, her security classification, or simply, her level of “willingness” to participate in treatment. More recently, the CSC has been piloting a project that would have prisoners assessed according to a 30-40 minute computerized survey (CSC, 2007b: 6). This process exemplifies Smith’s claim that institutions employ mental illness categories to control individuals’ “troubles” by fitting them in to a prescribed system according to “standardized terms and procedures” (1990b: 125) and “technologically refined sets of questions or ratings” (D. Smith, 2005: 191). The “intake assessment” is an example of how institutional subjects are “interrogated” and objectified in texts so that they may be “institutionally actionable” (Smith, 2005: 187).

Once assessed upon intake, prisoners may proceed through the next levels of health services. For specific ongoing issues and short term interventions, the CSC provides “Ambulatory Care” (see Figure 3, p. 98). This includes “therapeutic groups, maintenance, relapse prevention, and psycho-educational services” (Laishes, 2002: 28).

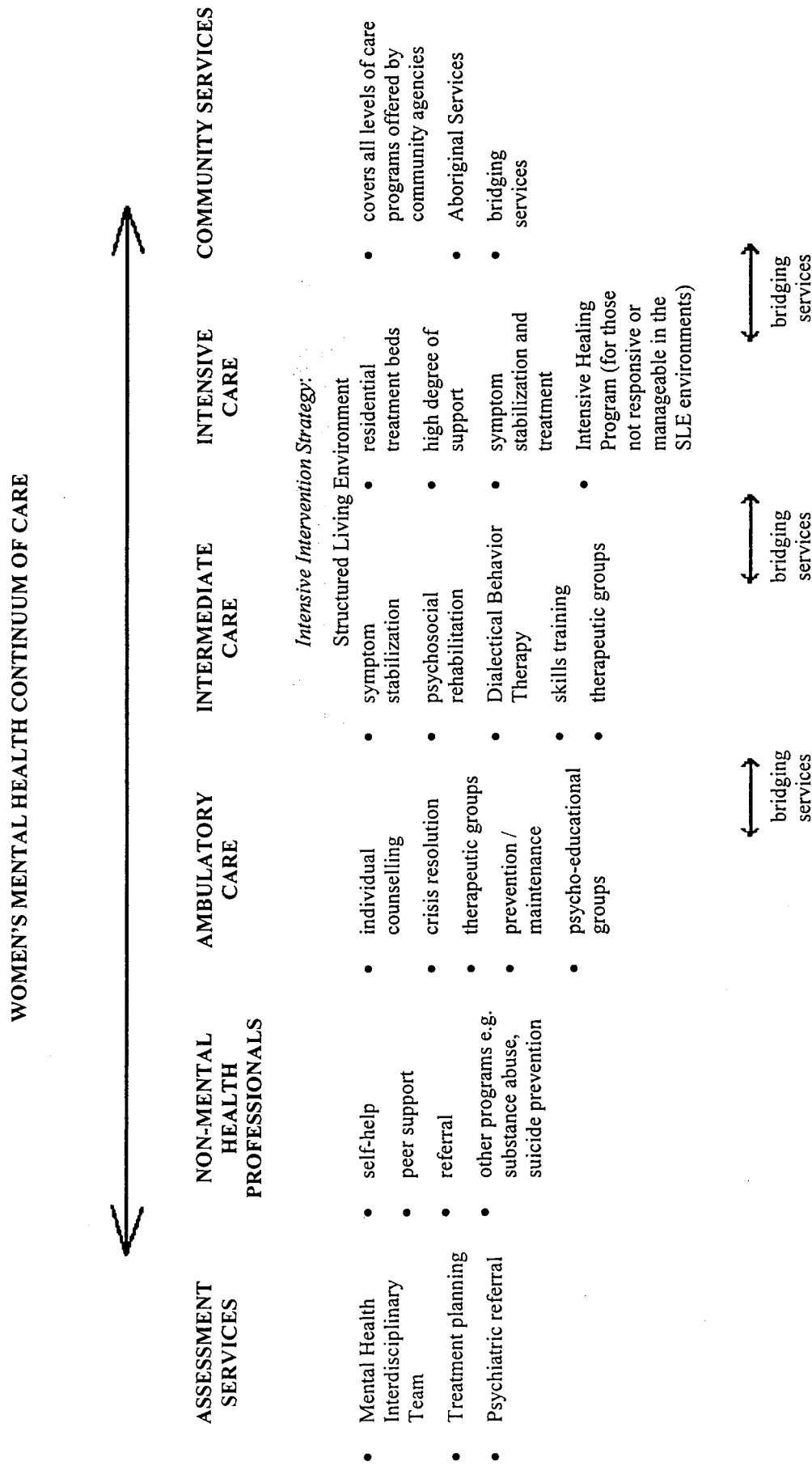
⁸ Not every level of the Continuum of Care will be explored and described here. For a comprehensive description of all levels of the Continuum of Care see the *2002 Mental Health Strategy for Women Offenders* (Laishes, 2002).

The issues that these types of treatment might address include eating disorders, substance addiction, or family death. Psychotherapy and counseling are also offered in this level of care, as well as programs to address living skills, surviving abuse, and education and literacy (ibid).

The next levels of the Continuum of Care, “Intermediate Care” and “Intensive Care,” are provided to women with “serious or deteriorating mental health problems” (Laishes, 2002: 21). The *Mental Health Strategy* states that most women provided Intensive Care are prescribed psychotropic medications (ibid.). They may also be moved to one of the residential treatment facilities; either the Churchill Unit of the Regional Psychiatric Centre in Saskatoon, or the Institut Philippe Pinel in Montréal. The *Mental Health Strategy* refrains from using the language of “committal,” instead saying that women may be moved there either voluntarily, or “if they have been deemed certifiable for psychiatric care” (Laishes, 2002: 22). By framing it this way, the Strategy thus evades addressing the removal of informed voluntary consent, a principal governing the provision of health services according to the CCRA, CCRR and the *Standards for Health Care* (CSC, 1992a, 1992b, 1994).

The Churchill Unit employs the Intensive Healing Program, the first ever program of its kind, according to CSC, for incarcerated women with self-injurious or assaultive behaviour (CSC, 2006: 7; Laishes, 2002: 22). Importantly, the *Mental Health Strategy* states that the purpose of this treatment is to transform “the thoughts and behaviours that often are the source of the women’s problems” (Laishes, 2002: 22). It is notable that the Strategy specifically frames the “source of the women’s problems” as stemming from

Figure 3
Continuum of Care Model⁹



⁹ Laishes, 2002, Appendix L: 24

the prisoners themselves, rather than in their past experiences of trauma or social inequalities. The DisAbled Women's Action Network, has argued that acts of self-harm are a common response for women with histories of abuse and violence, and that many women in federal prison engage in self-harm (Peters, 2003: 7). However, the Strategy frames the thoughts and behaviours of women who engage in self-harm as the 'true' source of women prisoners' problems, while simultaneously presenting them as an individual maladjustment on prisoners' behalves that have emerged in a social vacuum. The Strategy thus plays a significant role in determining the ideological frame imposed upon women who are provided with this level of mental health services—it is the prisoners themselves that need to be 'cured' of their problematic thought patterns, while their past experiences of social marginalization are negated and exempt from problematization.

Women who receive "Intensive Care" may be alternatively transferred to community-based mental health facilities, according to the *Mental Health Strategy* (Laishes, 2002: 21). Such community services include "mental health agencies, supportive housing, employment, social assistance, educational programs, substance abuse services, and Aboriginal communities/services" (Laishes, 2002: 33). However, the *Mental Health Strategy* admits that "Strategies for encouraging community involvement to support the reintegration of incarcerated women require ongoing development" (ibid.). Although this point garners little attention within the *Mental Health Strategy*, it provides the basis of one of the greatest criticisms of women's incarceration. There continue to be many calls for the CSC to relinquish the confinement of women prisoners, especially Aboriginal women and those with psychological problems, so that they may be

appropriately cared for in their own communities (CAEFS, 2002: n.p.; CHRC, 2003: 57; Correctional-Investigator, 2004: n.p.; Peters, 2003: 20). While it's notable that the Strategy states that more work is needed to encourage community reintegration strategies for women with "intensive" mental health needs, it fails to set any clear goals with regards to this reform, such as setting specific target dates and guidelines for modifying this strategy, or clarifying who is or would be developing this strategy further. As mentioned before, few women with severe mental health problems are actually moved back into community care once they have been sentenced. More often they are provided the *Intensive Intervention Strategy* which was developed as both a housing program as well as a therapeutic technique for women deemed to have significant mental health needs. The predominance of this program within women's federal prisons, and the marginalization of community reintegration strategies, suggests that the CSC has prioritized *expanding* carceral programs for women with mental health needs rather than developing strategies to relinquish their confinement.

The *Intensive Intervention Strategy* is a significant part of the "Continuum of Care," and includes both "Intermediate Care" and "Intensive Care." "Intermediate Care" may be provided to women who are believed to possess significant mental health problems, but who live in the general prison population. These women are offered one-on-one counseling and other various treatment options, although such options are not specified in the *2002 Mental Health Strategy*. This level of the "Continuum of Care" (reflected in Figure 3, p. 98) also includes the provision of Psychosocial Rehabilitation (PSR) and Dialectical Behavioural Therapy (DBT). Women provided with "Intermediate

Care” are overseen by a “Mental Health Interdisciplinary Team” which is composed of a “psychologist, nurse, parole officer, and ad hoc members” (Laishes, 2002: 14).

The *Intensive Intervention Strategy* has two distinct policies; one applied to those classified as Minimum and Medium Security, the *Structured Living Environment Operational Plan* (NIWG, 2002); and one for those classified as Maximum Security, the *Secure Unit Operational Plan* (NIWG, 2003). The Structured Living Environments (SLEs) house Minimum and Medium Security women, who are seen to possess “significant cognitive limitations or mental health concerns” (NIWG, 2002: n.p.). The second component of the *Intensive Intervention Strategy*, the *Secure Unit Operational Plan* (NIWG, 2003), is a separate mental health strategy for some Maximum Security female prisoners—those exhibiting “anti-social behaviour/criminal attitudes and emotional/mental health issues,” or those with “significant emotional and mental health difficulties...or...serious mental illness” (NIWG, 2003: n.p.), according to CSC. Despite that these populations may be considered more sensitive and vulnerable than the ‘general’ female prisoner population as a result of their cognitive needs and psychological problems, as mentioned earlier, the health policy for this population exempts them from numerous freedoms and protective measures mandated under the CCRA, the *Standards for Health Care*, the *2002 Mental Health Strategy for Female Offenders* and those afforded women living in the SLEs, namely medical confidentiality, least restrictive measures, informed voluntary consent, and confinement in segregation. Women confined to Maximum Security are not only segregated from other prisoners, they are also locked up in involuntary segregation at an alarmingly high rate—over the course of a year almost 75% of women with special needs had reported being placed in segregation

against their will (NIWG, 2003: n.p.). They are also placed in body restraints such as handcuffs, body belts and leg-irons, or accompanied by staff for all movements around Maximum Security units (ibid). While women living in the SLEs are to be treated according to “Least Restrictive Intervention,” one of the five principles for Mental Health provision to all women inmates according to the *2002 Mental Health Strategy* (Laishes, 2002), women in the Secure Units apparently do not benefit from this principle (NIWG, 2003).

Moreover, the *Intensive Intervention Strategy* states that Maximum Security women have high rates of past experiences of abuse and victimization which, it claims, contributes to their “behaviour difficulties” (NIWG, 2003: n.p.). Such statements indicate that the CSC prioritizes a management model of incarceration, whereby prisoners’ past experiences of abuse are framed as significant because they may undermine the institution’s ability to ensure inmate compliance, and not because women with such histories require special consideration and care. Women prisoners with past experiences of abuse, who may be most vulnerable to psychological distress from discipline, restraint and control, are in fact more likely to be subjected to restrictive practices authorized by the *Intensive Intervention Strategy* in Secure Units. In the CAEFS *Response to the 2002 Mental Health Strategy*, they state that “women with mental health issues are routinely over-classified under the current system; and, that their placement in environments that are strongly security-focussed [*sic*] is counter productive to their healing” (2002). In sum, there are a number of problems with CSC’s Intensive Intervention Strategy, particularly for women classified as both Maximum Security and those deemed seriously ‘mentally

ill.’ How these problems are particularly acute in the context of the treatments and therapies provided through the Intensive Intervention Strategy will be explored later.

Within the final level of the Continuum of Care, “Community Services,” the 2002 *Mental Health Strategy* states that it provides “Aboriginal Services,” “Bridging Services,” and that it “covers all levels of care programs offered by community agencies” (see Figure 3 on page 98). How these ambiguous levels of Community Care actually operate, however, are less clear, although it has been shown that CSC policy does not appear to prioritize Community Care strategies of any sort. The Strategy does reference “Elder Services,” but falls short of specifically identifying what such services involve beyond the participation of elders themselves. It does state, however, that Aboriginal elders are “important” and that access to elders should be ensured (Laishes, 2002: 30). The Commissioner’s Directive on Aboriginal Programming (in Laishes, 2002, Appendix J: 19) states that the objective of Aboriginal programs is, predominantly, to ensure Aboriginal inmates are offered culturally relevant programs which enable them to practice their cultural traditions. However, when it comes to specifying what this programming should entail, the Directive only states that the Core Programs should be consistent with the *Corrections and Conditional Release Act*, and, even more problematically, that the programs will only be offered to “replace” other programming in three circumstances: a) If non-Aboriginal inmates lack the appropriate “sensitivity” to Aboriginal inmates; b) If language is an issue for the inmate, and; c) if “the problems addressed by the program have a different basis for Aboriginal inmates than for non-Aboriginal inmates” (Laishes, 2002: Appendix J, 19).

This raises more than one concern. Aboriginal women are not granted access to Aboriginal programming in its own right, but rather, if there is some problem with non-Aboriginal programming. This directly contradicts the principles outlined in the CCRA which mandate the CSC to be “responsive to the special needs of...Aboriginal peoples” (CSC, 1992a: n.p.) and design programming for them (CSC, 1992a: n.p.). Furthermore, one of the grounds for “replacing” such programming is the lack of sensitivity on behalf of other inmates towards Aboriginal inmates. This policy then places the responsibility on other inmates for the implementation of Aboriginal programming rather than on the CSC’s structure and services. The development of Aboriginal programming and the Okimaw Ohci Healing Lodge is an admission on behalf of CSC that Aboriginal inmates do not benefit from ‘traditional’ incarceration, in large part due to racist attitudes towards them by inmates and staff alike. Its development was purportedly meant to address the lack of Aboriginal programming and the systemic racism faced by Aboriginal inmates throughout women’s federal prisons. It is clear that the CSC has not, in fact, developed substantial or comprehensive “Community Services” for Aboriginal inmates, despite its inclusion in the *2002 Mental Health Strategy’s* “Continuum of Care” (Laishes, 2002). The development of the Healing Lodge for women prisoners, and the marginalization of both “Community Services” and community reintegration strategies within CSC policy, suggests that the CSC has prioritized *expanding* carceral programs for Aboriginal women with mental health issues rather than developing strategies to relinquish their confinement into the community. Nevertheless, the *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004) does little to clarify what mental health services shall entail for Aboriginal women housed therein.

The Okimaw Ohci Healing Lodge is subject to somewhat distinct health policies, which include both biomedical psychiatric treatments and Aboriginal programming. While the *Okimaw Ochi Healing Lodge Operational Plan* (CSC, 2004) clearly defines physical health services offered women prisoners, psychological health services are not so clearly defined. Psychiatric services are offered by a contract psychologist six days a month, and all prisoners are assessed by nurses for risk of self-harm and suicide (CSC, 2004: n.p.). There is no mention, however, of mental health and healing programs inspired by Aboriginal knowledge or traditions. What remains consistent within the *Okimaw Ohci Operational Plan* is the plan's discursive emphasis on "choice" and "responsibility." The document states that health programming is intended to encourage prisoners to "assume the primary responsibility for their own health and make informed choices regarding their well being" (ibid.), the significant of which will be discussed in the chapter five.

Treatments and Therapies

As mentioned earlier, an alarmingly high number of women prisoners are diagnosed with some variety of mental disturbance while in custody of CSC (CSC, 2006: 40, 2007a: 4). The CSC states "With reference to mental health, one out of four women offenders admitted to federal custody in 2004 was identified as having a current mental health diagnosis" (CSC, 2006: 40), and this statistic remained consistent up until 2007 (CSC, 2007a: 4). The CSC also identifies the female prisoner population as having twice the rates of depression as male prisoners, and, compared to the general female population, "significantly higher incidence of mental disorders including: schizophrenia, major depression, substance use disorders, psychosexual dysfunction, and antisocial personality

disorder” (Laishes, 2002: 7). The CSC employs a variety of strategies, therapies and treatments to address the wide variety of psychological disorders with which women prisoners are diagnosed. The two most prominent are Dialectical Behavioural Therapy (DBT) and Psychosocial Rehabilitation (PSR), which will be discussed below.

Dialectical Behavioural Therapy (DBT), the most commonly discussed therapy in CSC’s health policy, is said to “embody” the five principles of *Creating Choices*: empowerment, responsible choices, respect and dignity, supportive environment, and shared responsibility (Sly & Taylor, 2003: 2). This therapy is provided to women who are seen to possess a variety of behavioural and emotional difficulties, including “self-destructive and/or suicidal behaviour, emotional dysregulation, severe interpersonal relationship problems, unstable and low self-image, and cognitive disturbances and distortions” (Laishes, 2002: 24), as well as those diagnosed with Borderline Personality Disorder (ibid.). CSC’s DBT literature frequently discusses emotional “dysregulation” (Fortin, 2004; Laishes, 2002; NIWG, 2003; Sly & Taylor, 2005) as the target of DBT — characterized as problematic behaviour associated with high sensitivity and extreme reactivity (NIWG, 2003: n.p.)—while the therapy aims to teach recipients emotional “regulation” (Fortin, 2004: 8). CSC’s DBT policy states that emotional dysregulation and problematic behaviour arise from “personal and environmental factors that reinforce maladaptive behaviours and/or inhibit the use of existing behavioural skills” (Fortin, 2004: 13).

From the outset, there are a number of problems with the policy’s stated goals of DBT. There is no acknowledgement that institutionalization itself, and the psychological distress associated with it, may be one such “environmental factor.” Such a perspective

fails to recognize that so-called “maladaptive behaviours” may have once been either logical responses or adaptive behaviours in strenuous or distressing circumstances (CAEFS, 2005: 13). Therefore, CSC’s provision of DBT may serve the function of medicalizing and pathologizing women’s responses to incarceration, and holding them responsible for emotional problems incurred from past experiences of distress, while teaching them to “abandon previous survival strategies in favour of new ‘thinking’ strategies” (ibid.). Furthermore, the manipulation of women’s emotional states is the goal of DBT which seeks to impose an assumed standard of ‘normal’ emotionality. This goal speaks directly to the regulatory and disciplinary power of psychiatric techniques (Kendall, 2000), and exemplifies CSC’s production of psychiatric ‘knowledge’ about prisoners which serves to justify institutional action taken upon them.

Other problems with DBT arise from the therapy’s practice of both categorizing and quantifying the mind. The philosophy of DBT reduces the mind into three mental states: reasonable, emotional and wise (Sly & Taylor, 2003: 17). Individuals are seen to act irrationally, or subjectively, while in either “reasonable,” or “emotional” states of mind. This dichotomous perspective of the mind is not only reductionist, but it adopts the traditional androcentric philosophy that emotionality obstructs rationality. Furthermore, DBT recipients are encouraged to both categorize and quantify their own emotional states according to a 0-7 point scoring range—a task that was admittedly frustrating for both participants and staff providing DBT (ibid.). Nonetheless, in CSC’s evaluation of DBT, staff framed the treatment as providing a “therapeutic environment,” while prisoners framed it as highly structured, where staff “watch and fix...behaviour” (Sly & Taylor, 2003: 12). These practices exemplify both the “standardized terms and procedures” (D.

Smith, 1990b: 125) and the “technologies of ruling” (Campbell, 2003: 16) employed by institutions so that people’s struggles may be quantified and translated into institutional ‘knowledge’ so that they may be managed by the institution. The measurement, calculation and documentation (Rose, 1991) of prisoners’ personhood allows them to be fit in to the institution’s pre-existing categories by having their “needs determined objectively” through their “interrogation” (D. Smith, 2005: 189). It also impacts the lived subjectivity of the prisoner, constructing their experience (Wright & Treacher, 1982: 6) of ‘mental illness’ by decontextualizing their mental states and behaviours, interpreting them instead as symptoms of their pathology (D. Smith, 2006a: 78).

Rather than providing a fundamentally “empowering” and “validating” (NIWG, 2003: n.p.) therapy, as CSC policy has claimed, the provision of DBT illustrates the ways in which institutions subordinate institutionalized subjects so that they may become “institutionally actionable” (D. Smith, 2005: 187). Importantly, CSC admits that one of the main objectives of DBT is to facilitate prisoners’ “ability to function effectively in an institutional setting” (Sly & Taylor, 2003: 3). This objective further evidences the everyday disciplinary and regulatory goal of the psy-sciences (Kendall, 2000: 86), especially in their provision in institutional settings, and lends evidence to Smith’s claim that institutions process people, not as individuals, but as “categories of persons,” that are defined by institutional discourses (D. Smith, 2005: 120)—in this case, psychiatry and therapy. DBT is employed as a technique of ruling within the CSC that serves to coordinate inmates to act in concert with the goals of the institution. However, therapies, treatments, or programs that seek to make effective institutional subjects conflate what’s best for the institution with what’s best for the institutionalized individual. It is clear that

the CSC prioritizes the management of prisoners through the provision of DBT rather than creating a therapeutic environment, free of subordination, that addresses the root causes of prisoners' psychological distress.

While DBT is provided to women who are deemed to possess emotional “dysregulation,” Psychosocial Rehabilitation (PSR) is provided to women who are deemed to possess serious mental illness or “severe psychiatric disabilities” (Sly & Taylor, 2005: 2). Like DBT, PSR seeks to address “problematic behaviour” (Laishes, 2002: 26), and, according to CSC, does so by embodying the five principles of *Creating Choices* (Sly & Taylor, 2005: 2). Ironically, PSR admittedly aims to treat mental problems that are caused by incarceration, including isolation, hopelessness, despair, and deviant behavior “learned through institutionalization” (NIWG, 2002: n.p.).

Women provided with PSR are evaluated according to 14 “Technology Sheets” which assess various aspects of their therapeutic progress with “quantifiable data” (Sly & Taylor, 2005: 3). (D. Smith, 2006a: 78). In the case of both PSR and DBT, prisoners described the therapies as unintuitive, overly-complicated, and full of jargon (Sly & Taylor, 2003, 2005). Like DBT, PSR constitutes a “technology of ruling” (Campbell, 2003: 16); it is employed through the interrogation of the prisoner with “technologically refined sets of questions or ratings” (D. Smith, 2005: 191). Pathologizing frames are built into the data sets, which allow the institution to impose the ruling perspective (Campbell, 2003: 16) by offering “contextually isolated accounts of the subject’s behavior” so that the behavior is interpreted as symptomatic of some pathology

Despite women prisoners’ criticisms of both DBT and PSR, CSC’s evaluations of the two therapies highlight their success and effectiveness. Both the *Evaluation of*

Psychosocial Rehabilitation Within the Women's Structured Living Environments (Sly & Taylor, 2005) and the *Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment* (Sly & Taylor, 2003) maintain a positive characterization of the therapies despite a substantial body of criticisms from staff and prisoners alike, especially towards PSR. Significantly, only three women prisoners participated in the *Evaluation of Psychosocial Rehabilitation* (Sly & Taylor, 2005), while 40 staff members participated. Forty-two staff members participated in the *Preliminary Evaluation of Dialectical Behavior Therapy* (Sly & Taylor, 2003), while only 23 women prisoners participated. Furthermore, in both evaluations, staff were provided the opportunity to fill out surveys in addition to their semi-structured interviews, whereas women inmates were not. Therefore, the data upon which CSC relied to evaluate both therapies drastically overrepresented staff and underrepresented women prisoners. Consequently, these evaluations produce a skewed 'knowledge' of the usefulness of the therapies, privileging the perspective of the staff while subordinating the perspective of inmates—those subject to the therapies. This illustrates a strategy in which institutions produce 'knowledge' which then comes to mediate "ruling practices" (Campbell, 2003: 16)—in this case, positive evaluations of CSC's primary psychiatric regimes used in women's prisons. The 'facts' produced by the employees of the prison are consequently ascribed more authority than those of prisoners themselves.

CSC further legitimizes the effectiveness of these therapies as objective knowledge through the use of statistics and selective quotes within the evaluations. The evaluations provide clear statistical data for such things as the percentage of women prisoners who moved into the Structured Living Environments voluntarily (70%), and the

percentage of staff who felt DBT was a “good idea” and highly satisfactory (48%) (Sly & Taylor, 2003: 10). However, if one is to fill in the statistical omissions within this information, almost a full third of women *did not* move into the SLEs voluntarily, and over half of staff *do not* feel that DBT is a “good idea.” Similarly, DBT recipients that were specifically critical of the therapies were not given the same statistical legitimacy, as the evaluation omitted a quantified statistic for such criticisms, merely stating,

While the majority of participants acknowledge that they are learning information and constructive skills that will assist them, *many* describe the components involved as “hard”, “difficult”, and “confusing” (ibid; italics mine).

Rather than providing specific statistical data regarding the critical evaluations of DBT and PSR, as is done with the positive evaluations, it is only mentioned that “many” prisoners evaluated the therapy negatively.

Both evaluations reiterate that the therapies are most effective when prisoners are “motivated” and willing to “work hard” (ibid.). This seemingly benign claim is problematic on a number of levels. Not only does it place the onus on prisoners for the therapeutic value of the techniques rather than on the therapy itself, it holds women responsible for the ineffectiveness of the therapy and their failure to succeed in a therapeutic context. This is particularly problematic in light of the number of women who expressed that they felt coerced into receiving the therapies, or moving into the Structured Living Environments (30%). In the case of PSR, the evaluation states, “Regarding the accomplishment of program goals, 50% of staff (4 of 8) reported that they think the goals are being achieved thus far. Those who do not feel that the goals are being met suggested that, although inmate participation in PSR is voluntary, some women may feel coerced to engage” (Sly & Taylor, 2005: 14). Not only are women coerced into this

therapy, some treatments and programs are exempt from the condition of voluntary consent (those where participation is deemed mandatory to achieve parole or release), and this condition increases the likelihood that prisoners may comply with therapeutic regimes in order to achieve release or parole. It is unknown, however, how often this may occur, because the CSC does not reveal which programs and treatments are exempt, nor does it “collect statistics about frequency of involuntary treatment.”¹⁰

Conclusion

This chapter has begun the process of investigating the “problematic” of CSC’s women’s federal prisons and mental health services by plotting a map of the institutional organization of federal women’s prisons, and analyzing policy texts for how they coordinate and are embedded in “institutional courses of action” (D. Smith, 2005: 86). This analysis began with the twelve policy texts selected as data, which were read selectively and analyzed for how they both “occur” and “activate” CSC processes by binding people together to act in concert to serve the goals of the institution (Campbell & Gregor, 2004: 32). The texts were mapped according to their level in the intertextual hierarchy to articulate the local sites of everyday activity with women’s federal prisons. This process then facilitates the interrogation of CSC’s institutional ‘knowledge,’ uncovering the social forces which extend beyond the local sites of women’s prisons.

The analysis identified three levels of data, and situated them within an intertextual hierarchy: the governing principles and regulations of CSC more broadly; women’s prison policy specifically; and mental health services in women’s prisons. The

¹⁰ This quote was taken from an email sent to me by CSC’s National Pharmacist, Craig Shankar, March 18th, 2008, upon my inquiry into the conditions under which “Involuntary Treatments” are administered, and the frequency with which this practice is exercised.

analysis began with the governing principles and regulations of CSC, examining the fundamental practices by which it's mandated to abide, and which regulate the activities within women's prisons specifically. The governing principles and regulations of the CSC proclaim to guarantee certain rights to all prisoners, and, additionally, project the appearance that they both consider and protect particular groups of prisoners who may be considered especially vulnerable: women, Aboriginals, and those with mental health problems. These policies also present significant limitations to how institutional concepts will be defined and understood, such as what constitutes discipline or "essential" mental health services. Within the analysis of this level of data alone, a number of problematic policies were observed. Significantly, CSC identifies what mental health services involve by providing an ambiguous and vague definition of 'mental illness' that would elicit such services. Not only does such a practice empower all CSC staff to initiate psychiatric interventions broadly, more worrisome are the consequences to prisoners who have been deemed in need of psychiatric intervention. Despite that CSC is apparently mandated to provide special consideration to those with mental health problems, it is clear that in practice prisoners deemed mentally 'ill' are either exempt from particular rights and freedoms in certain situations, such as informed voluntary consent, or simply denied the rights supposedly guaranteed to them by CSC, such as least restrictive measures and their assignment to security classification and segregation. While such contradictions are troubling in their own right, the significance that they have for women's prisons becomes clearer when connected of the next level of data.

Once CSC's broad governing policies were mapped and interrogated, it was then possible to situate the second level of data on women's prison policy for how it is

connected to and embedded within the first level. Women's housing and security classification policy were first added to the map, situating these practices within CSC policy which has proclaimed a new era of empowering and woman-centered penology. Despite the protections guaranteed prisoners in CSC's governing regulations, and the special consideration supposedly paid to Aboriginals, women, and those with mental health issues, women's prison policy ensures that women are frequently over-classified and denied the rights and consideration guaranteed within CSC's governing regulations. Aboriginal women and women deemed to have mental health issues are particularly vulnerable to these violations, which are illustrated in CSC's practice of security classification, segregation, restrictive measures, and coercion and involuntary consent to treatments. Such practices are antithetical to both 'empowering' penology for women and 'culturally-sensitive' penology for Aboriginal women in particular.

Once these two levels of data were analyzed, mapped and interrogated, it was then possible to situate the final level of data within the intertextual hierarchy, women's mental health services. Women's mental health policy aggressively co-opts the language of "women-centeredness" and "empowerment," appearing to prioritize women's well-being and healing through sensitivity towards their gendered histories or past experiences of victimization. While these policies pay token acknowledgment to the socio-politico-economic contexts of women's lives, in the same breath they deny the significance of such contexts and hold women individually responsible for both their criminality and mental health problems. Rather than expanding strategies to allow Aboriginal women and women with mental health problems to be cared for in less confining community environments, these policies indicate that CSC has in fact expanded institutional

programming for these vulnerable populations of prisoners. Moreover, this level of data exhibits significant aspects of CSC's institutional discourses. CSC's production of psychiatric 'knowledge' about women inmates and its mental health practices privileges the institutional perspective subordinating the perspective of inmates, employing pathologizing frames upon them so that they may be 'institutionally actionable.' Rather than 'empowering' women inmates, CSC's mental health services facilitate particularly restrictive conditions for women deemed to have mental health problems by employing a management model of therapy which seeks to make "effective" institutional subjects.

Such practices illuminate the ways in which institutional documents construct knowledge and legitimate institutional practices, by both selective use of quantitative data, and marginalizing critical and contradictory information. This 'knowledge' is then used to 'activate' social settings, such as legitimizing and establishing a therapeutic technique. Once this occurs, the activities of both staff and prisoners can be better manipulated to serve the interests of the CSC. The texts explored in this section establish the frames and discourses which are used to interpret and define prisoners within CSC policy. The purported "goals" of the institution's broad regulations—such as the protection of prisoners with mental health problems, least restrictive measures, and informed voluntary consent—can be overridden by "lower-order" policies. Consequently, certain 'practices' proclaimed within the texts can be said to be much more rhetorical than practical. It is now possible to move from this map of local, everyday processes of CSC women's prisons, having interrogated the institutional knowledge and discourses which appear in the texts, to make sense of such practices by identifying and tracing the translocal forces, or ruling relations, which shape these institutional practices. As we will

see in the following chapter, the problematic nature of CSC's treatment of women inmates, and Aboriginal women and women deemed 'mentally ill,' can be traced to ideological goals to which the CSC appeals in its policy.

Chapter Five: Translocal Forces and Ruling Relations of CSC

This chapter departs from the process of ‘mapping’ the organization of CSC to expose the underlying discourses, power relations and ideologies which are expressed in its textually-based objectified forms of knowledge (Campbell & Gregor, 2004: 40), and which subsequently structure the activities of the institution. Now that the map of CSC’s social relations in women institutions has been established, it is possible to move beyond the local sites of everyday institutional action and to make sense of these practices by tracing them to the extra-local forces and ruling relations that determine them. The process involves “exploring power as it arises in the textual coordinating of institutional work...to make social relations and organization based in or mediated by texts ethnographically observable” (D. Smith, 2005: 199). In so doing, Institutional Ethnography provides an alternative ‘knowledge’ to those offered by institutional paradigms and discourses (D. Smith, 2005: 10)—in this case, penology, medicine, and psychiatry. Several prominent discourses appear within CSC’s policy documents which elucidate the greater penal and medical ideologies to which CSC ascribes. Although CSC frequently refers to “woman-centeredness and cultural sensitivity,” “choice,” and “correction and rehabilitation,” as some of the guiding tenets of women’s institutional policy, these policies appear to be little more than rhetoric, rather than effective institutional praxis. As we will see below, CSC policies, and women’s health policy more specifically, are organized around other muted discourses which are inspired by the ideologies and power relations to which the CSC subscribes. These discourses serve to individualize, responsibilize and pathologize women prisoners which, I argue, prohibits the CSC from being able to provide ‘correction,’ ‘rehabilitation,’ or ‘healing’ them.

The CSC has drastically reorganized the facilities and policies of women's incarceration since the mid-1990s, when numerous task forces and reports accused the CSC of gender discrimination and inhumane treatment of women inmates. Between 2002 and 2004 alone, the CSC developed the *2002 Mental Health Strategy for Women Offenders* (Laishes, 2002), the *Structured Living Environment Operation Plan* (NIWG, 2002), the *Secure Unit Operational Plan* (NIWG, 2003), the *Program Strategy for Women Offenders* (Fortin, 2004) and the *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004) for Aboriginal women prisoners, all of which delineate both the structure and practice of women's carceral facilities, women's programming, and women's health policies. These policies declare themselves to be the inception and hallmark of a transition into a new era of gender- and culturally-sensitive praxis within CSC.

Throughout CSC's women's policy documents, the social and economic status of incarcerated women in Canada is frequently discussed. To some extent, CSC's policy texts acknowledge the connection between poverty, violence, racism, marginalization, and women's conflict with the law. But more importantly, these policies assert that CSC has taken these circumstances into consideration in the development of their policies, in some circumstances claiming that such an analysis forms the very basis for their gender- and culturally-sensitive programming. The role that mental health services play in gender-sensitive penology is significant, according to some CSC policy, because both 'healing' and 'correction' will only be achieved if the psychological and sociological problems incarcerated women have endured guide the development of services and programming. Although the structure of CSC's women's prisons have changed greatly since the years of the P4W, and their policies frequently reference women-centeredness

and cultural sensitivity, I argue that CSC's claims to such progress in their policies are more rhetorical than practical because CSC continues to employ penal practice that reinforces both gendered and racial discrimination. This analysis will illuminate the ruling relations which structure CSC policy, and shape institutional organization and discourses.

Three prominent ideologies were identified within CSC's policy texts, and will be contrasted with the rhetorical use of "empowering" language throughout the policies. It is these themes that indicate the ruling relations and ideologies to which CSC policy appeals, and which structure the everyday practices and social relations within women's federal prisons. First, I contrast the assertion throughout the texts of "woman-centeredness" and "cultural-sensitivity" within CSC policy, with a decontextualizing discourse. Arguing that CSC policy more accurately denies the contexts within which women are criminalized, while merely rhetorically recognizing the socio-politico-economic contexts from which federally sentenced women have come, and to which they will be returned upon release, I illustrate that the policies both flatly deny the role of sexism and racism in women's crime and mental health problems, and appeal to sexist and racist ideologies themselves. Secondly, I contrast the assertion found in the texts that the CSC provides women inmates with "choices," with an individualizing and responsabilizing discourse. I argue that the purported provision of "choices" to women inmates is erroneous; rather than providing women inmates with more meaningful choices in their incarceration, I illustrate that the policies instead frame crime and psychological distress as poor individual choices for which women inmates must be held responsible. Finally, I contrast the assertion throughout the texts that federal women's

prisons provide “correction” and “healing” to women inmates, with a medicalizing and pathologizing discourse. I argue that CSC pathologizes women prisoners by both decontextualizing and medicalizing their mental states, and holds them individually responsible for their own “correction.”

I conclude that this ‘new era’ of so-called ‘empowering’ penology is better characterized by a denial of the connection between social marginalization, criminality, and psychological problems. Consequently, women’s crime and psychological problems are decontextualized, and greater penal and psychiatric discipline for both Aboriginal women and women with psychological problems becomes justified through CSC’s production of carceral and psychiatric knowledge. In conclusion, I argue that incarceration is antithetical to empowerment, choice, and healing, and that the CSC in fact appeals to the very ideological forces that produce the conditions for women’s criminality and mental distress.

Contrasting “Woman-Centeredness/Cultural Sensitivity” with Decontextualization

The principle of creating “woman-centered” prisons was first introduced seriously in *Creating Choices* (1990), the report by the Task Force on Federally Sentenced Women. CSC’s policies frequently refer to this report as a seminal document in the transition towards “woman-centered” programming. The report identified five principles with which to change CSC’s women’s carceral practice: Empowerment; Meaningful and responsible choices; Respect and dignity; Supportive environment; and Shared responsibility. Since the publishing of *Creating Choices*, these principles were first discussed in the *Program Strategy for Women Offenders*, which cites “woman-centeredness” as the primary principle governing the development of women’s

programming (Fortin, 2004: 6). This principle mandates that CSC recognize the greater context within which women live, including the “socio-political and economic environment from which women offenders have evolved and to which they will return to once released” (ibid.), as well as the significance of interpersonal relationships in women’s emotional well-being. The *Program Strategy* also suggests that women require a carceral environment that fosters empowering relationships rather than ones that mirror past experiences of loss or abuse (Fortin, 2004: 5).

As stated earlier, the Canadian Human Rights Commission characterizes the federally sentenced women population as disproportionately uneducated, single mothers, survivors of sexual and physical abuse, Aboriginal, or addicted to substances (CHRC, 2003: 5). In some of its policies, CSC recognizes these social contexts, and importantly, highlights their connection to women’s criminalization. For example, the *Structured Living Environment Operation Plan* states,

Women's offences are...linked to women's generally inferior socio-economic circumstances, which often include poverty, racism, and violence. There is considerable agreement on these common characteristics of women offenders: most are poor and lacking in marketable skills; they often demonstrate dependence on welfare, alcohol, and men; and are often single parents, solely responsible for childcare (NIWG, 2002: n.p.).

Similarly, the *2002 Mental Health Strategy for Women Offenders* associates federally incarcerated women’s past histories to high levels of mental health problems. The Strategy declares that “Some mental health problems experienced by women offenders can be linked directly to past experiences of sexual abuse, physical abuse, and assault, as well as substance abuse and poverty” (Laishes, 2002: 6). And further still, the *Program*

Strategy for Women Offenders (Fortin, 2004) mandates the development of programming which is informed by these demographics. It states,

Common issues are low self-esteem, dependency, poor educational and vocational achievement, parental death at an early age, foster care placement, constant changes in the location of foster care, residential placement, living on the streets, participation in the sex trade, suicide attempts, self-injury, and substance abuse...*Emphasis in correctional programs must be on factors that led to incarceration* (Fortin, 2004: 5, 6, italics mine).

Such recognition of social factors that lead to women's problems with the law in CSC prison policy is a significant advancement. If CSC is mandated to "recognize" social inequalities that women face, and develop programming in light of these contexts, the implication for policy and the organization of CSC would be enormous. While it is clear that some CSC policies now make reference to social contexts of women's lives, the inclusion of sociological explanations for women's crime and mental ill health are still supplanted with penal discourses that blame women for their crime and hold them responsible for their own 'correction' and 'healing.' As we will see, CSC has failed to move beyond this textual recognition of the contexts of women's lives, to actually *transform* women's prison policy to account for the socio-economic conditions.

Within the same strategy mandating that 'causal factors' of women's crime must be considered in programming, a different and contradictory discourse emerges simultaneously. The *Program Strategy for Women Offenders*, while recognizing women's past experiences of abuse and marginalization, clarifies that there is, in fact, no connection to such circumstances with criminal activity. It states that "surviving abuse and trauma has not been linked directly to criminal activity" (Fortin, 2004: 13), and instead, that past violence and abuse are important because they undermine women's

ability to “adjust” and “benefit” from incarceration (CSC, 2004: ANNEX E). This statement exemplifies two significant aspects of CSC’s carceral paradigm: first, violence against women is not, in fact, connected to women’s criminal activity. It is not clear, then, how CSC explains why such a high proportion of incarcerated women have had past experiences of abuse and mental health problems. Eighty-two percent of federally sentenced women, and 90% of Aboriginal women, report past experiences of physical and sexual assault in their lives (CAEFS, 2004; Peters, 2003: 5).

Secondly, such a statement indicates that women’s past histories of abuse are significant from the institutional perspective because they prevent women from “adjusting” to institutional demands. The *Intensive Intervention Strategy* for the Secure Units expresses a similar sentiment by stating that women in Maximum Security prisons possess past histories of abuse, and that these experiences contribute to “behavioural problems” (NIWG, 2003: n.p.). Here, CSC has imposed a management model of corrections on women with past histories of abuse, highlighting their inability to be effective institutionalized subjects, and simultaneously, flatly denying the role of these contexts in women’s criminality. Past experiences of abuse are seen to threaten inmates’ ability to “adjust” to their institutionalization, and undermine their compliance to institutional demands. CSC’s emphasis on inmate compliancy is a typical expression of Total Institutions (Goffman, 1961). Inmates in Total Institutions are subject to constant management and surveillance, amongst other techniques, which contribute to the “mortification” of the inmate’s self—the erasure and negation of the individual so that institutional compliancy may be imposed. Total Institutions have procedures for “programming” inmates so that they may be “shaped and coded into an object that can be

fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations” (ibid.: 16). CSC’s policies illustrate one such technique: women with past histories of violence, upon whom it may be harder to enforce compliance, are framed as having “behavioural problems” and failing to “benefit” and “adjust” well to institutions, thus responsabilizing them for their personal underachievement in prison, and justifying institutional procedures to be imposed upon them, such as programming or ‘therapeutic’ regimes, as seen in *The 2002 Mental Health Strategy for Women Offenders* (Laishes, 2002).

CSC’s Mental Health Strategy for women inmates employs a similar practice by associating past experiences of abuse and marginalization with mental health needs and criminal behaviours:

Many women offenders are from marginalized backgrounds and situations that may include poverty, discrimination, abuse, and chemical dependency. Programs and services must...address the social context of women’s lives *and target those areas that have contributed to their criminal behaviour* (Laishes, 2002: 10, italics mine).

While it is commendable that the mental health policy recognizes sociological forces in women’s criminality, they are not framed as “causes” of crime but as “areas that have contributed to crime” that programming needs to “target.” However, incarceration itself cannot “target” poverty, abuse, or discrimination, or any other social *condition* that leads to conflicts with the law. Furthermore, mental health programs do little to ‘heal’ women whose mental health problems arose from these conditions if they will simply be returned to them once again when they are released. This assertion merely decontextualizes the role of social forces in women’s crime, by framing them as merely “factors” in criminality. Criminality is thus located in prisoners themselves, as though women

prisoners possess an ‘intrinsic criminality’ which must be “corrected” through mental health programming.

The same ideological position can be observed in CSC’s mental health treatments, such as the Intensive Intervention policies, which pathologizes women’s responses to incarceration, locating behavioral “problems” inside women themselves rather than in the prison system or social contexts more broadly. Once women prisoners have been diagnosed with behavioural difficulties or mental illness, they are most often transferred to the Structured Living Environments or Secure Environments (Maximum Security), in order to be treated through the Intensive Intervention Strategy. The Intensive Intervention Strategy policy associates women’s past experiences of abuse and victimization to greater “behavioural difficulties” (NIWG, 2003: n.p.) which are characterized by, —

impulsive responses to frustration, boredom, objections to requests or orders given by staff, relationship issues or...allowing the inmate to gain some sense of power and control over others or the environment (ibid.).

Several troubling deductions can be made from this assertion. Firstly, women prisoners’ “behavioural difficulties,” particularly their refusals to acquiesce to institutional order, are admittedly a response to institutional environments. Yet these behaviours are framed as symptoms associated with past experiences of abuse and are used to justify the imposition of the Intensive Intervention Strategy. Secondly, according to the National Implementation Working Group (NIWG) for the Intensive Intervention Strategy, these carceral environments provide greater “structure,” and more “present” staff, including mental health professionals (NIWG, 2002: Appendix A). Therefore, this is an implicit acknowledgement, then, that women who have past experiences of abuse and trauma are likely to be labeled as having “behavioural problems,” thus warranting a transfer to a

facility that involves greater regimentation, surveillance, and intervention by mental health staff, because they are difficult for CSC to manage. CSC's association between "behavioural difficulties" or "adjustment problems" and greater mental health needs in either Aboriginal women or women with past histories of abuse indicates that CSC conflates "high-risk" with "high-needs," and prioritizes security over treatment when it comes to mental health services.

These policies may appear to be "woman-centered" and "empowering" by tokenizing the systemic oppression faced by women, but the mere acknowledgement of oppression in CSC policy does not in fact achieve "woman-centered" or "empowering" penal practices in and of themselves. In fact, by simultaneously decontextualizing the conditions within which women commit crimes, and denying the role of past experiences of oppression, these policies play a significant role in justifying and shaping institutional action taken upon women inmates. This process is not only apparent in CSC's failure to achieve "woman-centered" penal praxis, but it is also apparent in CSC's failure to achieve "culturally-sensitive" penal praxis for Aboriginal inmates.

Creating Choices provided significant and unforgiving exposure of the discrimination faced by incarcerated Aboriginal women when it was published in 1990. The report gave voice to Aboriginal women who complained of violent and systemic racism, labels, and the severance from their culture and elders experienced in prison (TFFSW, 1990). The Task Force called on the CSC to recognize the lived realities of violence, poverty, and colonization that Aboriginal women have faced:

Prison cannot remedy the problem of the poverty of reserves. It cannot deal with immediate or historical memories of the genocide that Europeans worked upon our people. It cannot remedy violence, alcohol abuse, sexual assault during childhood, rape and other violence Aboriginal

women experience at the hands of men. Prison cannot heal the past abuse of foster homes, or the indifference and racism of Canada's justice system in its dealings with Aboriginal people. However, the treatment of Aboriginal women within prisons can begin to recognize that these things ARE the realities of the lives that Aboriginal women prisoners have led. By understanding this, we can begin to make changes that will promote healing instead of rage (TFFSW, 1990: n.p.).

The CSC has since developed programming it describes as “culturally-sensitive”, which aims to ‘recognize’ the lived realities of Aboriginal women. Most significantly, CSC developed the Okimaw Ohci Healing Lodge to address systemic discrimination against Aboriginal women. The *Okimaw Ohci Healing Lodge Operational Plan* (CSC, 2004) includes in its objectives restoring “hope and dignity” to female Aboriginal inmates, as well as “rebuilding communities” for Aboriginals inside and outside of prison (CSC, 2004: n.p.).

Despite CSC policies that mandate “appropriate” programming for Aboriginals (see for example CSC, 1992a; CSC, 1992b, 2004; Fortin, 2004; Laishes, 2002: Appendix J), the CSC has done little to comprehensively integrate “Aboriginal programming” into women’s prisons, and the clarification and mandate of existent programs within CSC policy is marginal, at best. While some policy has referred to strategies that would allow Aboriginal inmates to be released into their communities rather than be incarcerated in prisons, the CSC has also largely failed to achieve its directive to allow Aboriginal people to be relinquished into the care of their community if requested, as mandated by the *Corrections and Conditional Release Regulations* (CSC, 1992a: Section 84.1). No policies examined in this analysis cite any references at all to such a practice for Aboriginal women. Rather, the CSC has expanded institutional development to incarcerate Aboriginal women, most notably through the development of the Okimaw

Ohci Healing Lodge. The Healing Lodge is the only federal women's prison which purports to comprehensively integrate Aboriginal philosophies and elders into its practices. However, not only do few federally incarcerated women have access to the institution, it has been argued that the Healing Lodge cannot be considered either "empowering" or integrated with Aboriginal philosophy as it is first and foremost a penal institution (Faith, 1995; Monture-Angus, 2000).

Aboriginal women may also face racial discrimination leading to greater levels of psychiatric intervention and control. CSC's *Ten Year Status Report on Women's Corrections* suggests that Aboriginal women are more likely to have "adjustment problems" (CSC, 2006: 28) resulting from prior incarcerations and substance abuse problems, and that they may therefore require "more intensive treatment interventions such as those offered at the women's unit at the Regional Psychiatric Centre" (ibid.). This suggestion is further evidence that the CSC favours the institutionalization of Aboriginal women over returning them to their community to be cared for.

Additionally, Aboriginal women are disproportionately classified in both Maximum Security and segregation (CSC, 2006). Not only does this speak to systemic discrimination within CSC's classification system, policies, and decisions by prison staff, it indicates that CSC activities actively seek to impose extraneous discipline and restrictions of Aboriginal women disproportionately. However, the CSC does not frame these decisions as racist, but justifies additional institutional action taken upon these individuals on a case-by-case basis in the production of their institutional 'knowledge' within texts. While CSC polices may rhetorically "recognize" the contexts of

discrimination that Aboriginal women face both within prisons and outside, CSC policies do more to decontextualize women's marginalization.

Despite the appearance of CSC's commitment to "culturally-sensitive" policies, there continues to be severe systemic discrimination towards Aboriginal women in prison. To this day Aboriginal people remain overrepresented in both men's and women's federal prisons, but the relative disproportion is particularly high for women (CHRC, 2003: 6). In fact, the CSC's *Ten Year Status Report on Women's Correction* (CSC, 2006) reveals that the rate Aboriginal women have been incarcerated has actually grown over the last fifteen years. Rather than holding the justice system accountable for the increasing criminalization of Aboriginal people, however, the report acknowledges the existence of "systemic" problems blamelessly, stating that this discrimination is a reflection of "issues that go well beyond the capacity of CSC alone to remedy" (CSC, 2006: 23). It suggests, instead, that the CSC "plays a fundamental role in potentially reducing re-incarceration rates" (ibid.). While it's true that the CSC plays no role in how many Aboriginal women are convicted of crimes, it certainly determines how long women are kept behind bars, the treatment and conditions of their incarceration, and whether or not they are relinquished into the control and care of the community. By negating the CSC's role in systemic racism in the criminal justice system, the discrimination that Aboriginals face is decontextualized and minimized within CSC policy.

It has been argued in previous research on women's federal prisons that CSC must recognize the contexts within which women become criminalized or develop mental health problems. The Canadian Human Rights Commission's condemning report on

CSC's treatment of women prisoners, *Protecting their Rights*, concluded, "Women's most common pathways to crime involve survival efforts that result from abuse, poverty, and substance abuse. Research suggests that all of these factors are interconnected" (CHRC, 2003: 71). Similarly, the Canadian Association of Elizabeth Fry Societies has criticized the 2002 *Mental Health Strategy for Women Offenders* with a damning report, stating that as long as "high-risk" and "high-needs" remain conflated in CSC's institutional practice; "women with mental health needs will continue to be seen as "security" or "discipline" problems and will continue to be "treated" with the segregation, deprivation and punishment that so exacerbates their conditions—and even creates new ones" (2002: n.p.). In regards to Aboriginal women, Mohawk activist and professor Patricia Monture-Angus has asserted that Aboriginal women's behaviour can be misinterpreted by prison staff who then resort to psychiatric and pharmaceutical strategies to intervene (2002: 23), many of whom are disproportionately classified in Maximum Security (CHRC, 2003; Correctional-Investigator, 2004; NIWG, 2003) where they are subject to greater restrictions and surveillance. The Canadian Human Rights Commission's 2003 report, *Protecting Their Rights*, declares that the CSC's security and segregation policies violate Aboriginal women's human rights since they are unfairly classified as Maximum Security and frequently placed in non-voluntary segregation (CHRC, 2003: 28). CSC's Correctional Investigator corroborated this claim, stating that CSC's classification system "results in a huge over representation of Aboriginal women being classified as Maximum Security" and that CSC's classification system is "totally inappropriate for Aboriginal offenders" (Correctional-Investigator, 2004: n.p.). These

calls indicate that there remains an urgent and considerable need for the development of a carceral paradigm that is responsive to systemic factors that lead to women's criminality.

The everyday practices of the institution, mapped earlier in chapter four, make more sense once they have been connected and tied to these extra-local forces which shape and organize institutional action. These powers are informed by the institutional discourses and ideologies which constitute the ruling regimes of the institution, and can be observed in textual forms, for how they coordinate institutional action. CSC policy may proclaim that it has achieved a new era of "empowering," "woman-centered" and "culturally sensitive" penology, but merely acknowledging the socio-politico-economic contexts of women's lives in policy does not constitute a feminist or anti-racist model of penology in and of itself. More important are actual practices of the CSC in its everyday local organization, and the institutional ideologies which structure those practices. Organizationally, CSC appeals to a neo-liberal carceral paradigm that holds women personally responsible for their crime and mental ill health by decontextualizing the circumstances within which they arise. As we have seen, CSC policy more often flatly denies that the social contexts from which women inmates come plays a role in their criminality, and in some cases justifies greater institutional subjugation upon women who have endured serious systemic inequalities. This is particularly true for Aboriginal inmates who are exceptionally vulnerable to over-classification and restriction in women's federal prisons. CSC's emphasis on a management model of penology indicates that the paramount concern of the institution is, in fact, producing inmates who are "institutionally actionable" (D. Smith, 2005: 187); those who will comply with, and be shaped by, institutional demands. Rather than relieving the disempowering conditions of

women's lives, 'correctional' penology maintains the very power structures that sustain them: gendered, racial, and socio-economic oppression. If CSC's "empowerment" model of corrections for women inmates seeks to "target those areas that have contributed to their criminal behaviour (Laishes, 2002: 10), the CSC has erroneously instituted programming that reinforces the very structural inequalities that provoke criminality in the first place.

Contrasting "Choice" with Responsibilization and Individualization

One of the most prominent concepts present in CSC's women's policy is that of "choice." Like CSC's rhetoric of "woman-centered" and "culturally-sensitive" penology, its adoption of a "choice" rhetoric was born from *Creating Choices* which emphasized the importance of offering federally sentenced women meaningful choices while incarcerated (TFFSW, 1990). Some of the choices that women prisoners reported they needed included the right to refuse psychiatric intervention, and more contact with Aboriginal elders. Such choices, according to the report, would allow incarcerated women to be rightfully empowered through their incarceration. *Creating Choices* points out that with choice and empowerment comes responsibility—one of the five principles the report suggests should define CSC's women's penal policy. Thus, if women can be said to have choices in their incarceration, then they can also be said to be responsible for themselves as well as their institutional 'correction.' But the report also makes the connection between women's limited life choices more broadly, and the role this plays in their criminalization. It would be through greater opportunities in life, the report concludes, that criminalization could be prevented to begin with, and incarceration would cease to be "be the intervention of choice" (TFFSW, 1990: n.p.).

CSC has largely seized on the choice rhetoric set out in *Creating Choices*, making it one of the most common discourses within its new “woman-centered” program model. However, CSC’s use of the choice rhetoric is less related to the intentions outlined in *Creating Choices* of providing women prisoners with meaningful opportunities and control of their carceral circumstances, and more closely related to a carceral paradigm that has allowed the CSC to responsibilize women in prison. Social explanations for women’s crime, mental ill health, and difficulties within the prison environment are eschewed and supplanted with individualizing and responsibilizing discourses that hold women responsible for their own circumstances, “crime” and “correction.”

CSC’s new era of women’s prison policy advocates the use of gender-specific penology for women inmates, in following with the recommendations made by *Creating Choices*. CSC’s *Ten Year Status Report on Women’s Correction 1996-2006* characterizes the changes made to women’s prison policy as a new standard of practice that is “sensitive to the unique situation of women offenders” (CSC, 2006: 36). This is said to be achieved by taking the social contexts of women’s lives into account in the development of prison programming and initiatives (ibid.). However, this acknowledgement is only made while simultaneously reinforcing women’s responsibility for their criminality. The *Ten Year Status Report States*, “While women offenders are *accountable for their behaviour*, interventions must take into account the social, political, economic and cultural context unique to women in society” (ibid., italics mine). Similarly, while detailing past experiences common amongst to incarcerated women—“low self-esteem, ... foster care placement, ... residential placement, living on the streets, participation in the sex trade, suicide attempts, self-injury, and substance abuse”—the

Program Strategy for Women Offenders immediately states that “‘Crime is a *choice*, or series of choices, made according to the social context’ and mediated by an individual’s *perception* of her environment” (Fortin, 2004: 5, italics mine).

While acknowledging social contexts that lead to women’s crime, such declarations actually negate the role of social forces in criminal activity by framing crime as a free choice that emerges from a misguided “perception” of one’s environment or needs. However, socio- and economic-marginalization, absolute poverty, abuse, or racism, can not reasonably be characterized as free “choices,” and as CAEFS has argued, neither can survival strategies employed by women to escape these circumstances be considered “choices” if the alternative is homelessness, death or any other form of harm (CAEFS, 2005: 8). Women’s crime, then, can often only be understood as a “choice” only in so far as the alternative choice is greater harm to her well-being. This is clearly not the definition of “choice” originally intended by the Task Force on Federally Sentenced Women.

Just as crime is framed by the CSC as a choice governed by the laws of free will to which women must be held accountable, so too is mental health. Women inmates are responsabilized for their mental well-being, particularly for their own ‘healing’ through their participation in available mental health services within federal prisons. Several women’s health policy documents, including the *Standards for Health Care* (CSC, 1994), the *Okimaw Ohci Healing Lodge Operation Plan* (CSC, 2004), *Preliminary Evaluation of Dialectical Behavioural Therapy Within a Women’s Structured Living Environment* (Sly & Taylor, 2003), and the *Evaluation of Psychosocial Rehabilitation Within the Women’s Structured Living Environments* (Sly & Taylor, 2005), declare that women

inmates are given the “choice” to participate in mental health services, and for which women must assume “primary responsibility.” Similarly, the most broad health policy document for both male and female prisoners, the *Standards for Health Care*, states that one of the primary principles of CSC’s health services is that “Inmates will bear the primary responsibility for maintaining and improving their individual and collective health” (CSC, 1994: 3). This sentiment is echoed in the *Okimaw Ohci Healing Lodge Operational Plan* which declares that health services enable “the residents to assume the primary responsibility for their own health” (CSC, 2004: n.p.); participating in institutional health services and therapies is one of the choices they may make to assume this responsibility. CSC’s recent evaluations of their two main psychiatric therapies, Dialectical Behavioural Therapy (DBT) and Psychosocial Rehabilitation (PSR), champion their development as “a major step toward *implementing choices*” within the SLEs by “assisting individuals to assume responsibility and function as actively and independently as possible” (Sly & Taylor, 2005: i). Similarly, health policies are introduced in the *Okimaw Ohci Healing Lodge Operational Plan* by stating that health service programming “enables the residents to assume the primary responsibility for their own health” (CSC, 2004: n.p.). On numerous occasions, CSC policies emphasize that incarcerated women are given the choice to take responsibility for their mental health status through their participation in institutional treatments.

Beyond the responsabilization of women inmates for both their criminal acts and mental well-being, CSC also holds women responsible for everyday operations of the prison, deflecting responsibility away from staff or the prison system itself. Women inmates’ actions, particularly unruly or aggressive behaviour, is framed as an inexcusable

choice that warrants institutional discipline, even when CSC's own research indicates that such behaviours often result from provocation by staff (NIWG, 2003: n.p.). CSC's application of the choice rhetoric is taken to extreme lengths at times, as exemplified in policies regarding the use of Emergency Response Teams (ERTs). Citing the "philosophy" of *Creating Choices* as the guideline for emergency response, the CSC states:

Following the negotiation stage, a women-only ERT may be called upon to physically intervene. At that time, the ERT will provide clear verbal direction to the offender as to how the team will proceed. There will be an opportunity for the offender to do what is requested of her *on her own* (allowing her a choice), prior to them entering the cell/area and bringing the situation to a conclusion. For example, in pre-planned use of force situations, an offender will be advised that she will be sprayed with a chemical agent if she does not comply with orders; subsequently, she is given an opportunity to comply (CSC, 2006: 30, italics in original).

Such a policy implies that the choice between being sprayed with a chemical agent or not is a meaningful or responsible choice now offered to women inmates. Although the CSC appears to have improved its policies since the days of the P4W and the infamous riot in which women were strip-searched by male guards, being given a choice to be sprayed with a chemical agent can hardly be considered a "choice" that one is "free" to make.

Although CSC frequently proclaims to offer women inmates "choice," which is said to reflect the principles of empowerment and woman-centeredness as prescribed by *Creating Choices*, the use of "choice" in CSC policy sheds light on the institutional discourses and ideologies to which CSC appeals. Policy documents for women's health strategies cite *Creating Choices*' prescribed principles—shared responsibility, and meaningful and responsible choices—as the foundation for their implementation (CSC, 2004: n.p.; Sly & Taylor, 2003: 2, 2005: i). However, women cannot be said to be

'primarily' responsible for their own health when it is known that socio-politico-economic factors play a decided role in individuals' health status. Furthermore, they cannot be expected to "assume responsibility" for their health when most prison conditions are out of their control—security classifications, daily routines, meal plans, sentence conditions, staff liaisons, involuntary segregations, involuntary treatments—from the most insignificant aspects of their incarceration to the most consequential conditions, inmates are not given choice. Rather than providing women with real and meaningful choices and control over their carceral experience, the use of a choice discourse throughout CSC's policies responsabilizes women inmates. References made to the socio-political contexts of women inmates' lives amounts more to rhetorical tokenism than practically integrated, radical, and alternative carceral practices that reflect gender- or culturally-sensitive programming. Within CSC policy, women are further subjected to individualizing and responsabilizing discourses that hold them personally responsible for their mental ill health and their failure to comply with institutional practices. Not only do women inmates have little choice about their carceral conditions, it has been shown that they are also frequently coerced into psychiatric and therapeutic programming with the express intention of disciplining them to follow institutional order.

It is particularly significant that women at the Healing Lodge are expected to assume "primary responsibility" for their own health and well-being, given the greater context of the lived reality that many Aboriginal women face outside prison including high rates of abuse, poverty and the pervasive consequences of colonization. The Healing Lodge Plan explicitly states that there is no "demonstrated link between surviving violence/abuse/trauma and criminal behaviour" (CSC, 2004: n.p.). This noteworthy

institutional 'fact' denies that abuse and victimization play a significant role in Aboriginal women's criminality and mental health, yet an undeniable connection between violence, criminality and mental distress can be clearly observed in the demographic of incarcerated women. The discrimination Aboriginal women face in Canadian society, including high rates of victimization and murder, the destitute economy of many Aboriginal communities, the criminalization of Aboriginal people in the justice system, the assimilation of Aboriginal culture, particularly through the destructive legacy of Canada's Residential school system, all constitute social, political and economic factors which may lead Aboriginal women into conflicts with the law. Nowhere within the policy for the Healing Lodge, nor any other governing policy documents, does the CSC recognize the role that the justice systems itself has played in sustaining the very systemic oppression that leads to Aboriginal women's ill health. Although the Healing Lodge aspires to "empower" women inmates (*ibid.*), it is difficult to empower incarcerated individuals when prisons are ultimately about discipline, control and punishment, not to mention the removal of an individual's rights. Rather, the CSC policy frames incarceration as a 'correctional' solution to Aboriginal women's crime, subsequently justifying psychiatric intervention for the "adjustment problems" that they exhibit (CSC, 2006).

CSC's use of the "choice" rhetoric is most significant because it employed in order to legitimize its new era of reforms within women's penal practice by framing new policies as a reflection of an improved, anti-sexist and racist prison system. In so doing, underlying ideologies of prison policy become evermore invisible, shielding the CSC from criticism. It is clear, however, that the CSC has co-opted the concept of "choice,"

not to provide incarcerated women with more meaningful choices in their carceral conditions as it was originally intended in *Creating Choices*, but to responsibilize women for their criminality and mental health status. The responsibilizing discourse in CSC policies is a significant ruling technique and plays a prominent role in mandating the organization of women's federal prisons. As illustrated in the previous section, the policies make a point to flatly deny the connection of crime and mental ill health with poverty, violence, assimilation, or other forms of subjugation, and subsequently, frame criminality and mental ill health as poor or misinformed choices made by inmates for which they must take personal responsibility in order to achieve 'correction' and 'healing.' In so doing, social inequalities are negated in CSC policy, and supplanted with a neo-liberal ideology which reinforces the sexist, racist and classist conditions which lead many women in crime and mental ill health to begin with.

Contrasting "Correction and Healing" with Medicalization and Pathologization

Medicalization and pathologization are complimentary social processes which construct social knowledge about the mind by eschewing social explanations for problems and supplanting them with biomedical and psychiatric diagnoses. While medicalization is a process whereby non-medical problems become defined and treated through medicine more broadly (Conrad, 1992: 209), pathologization involves defining behaviours as "symptomatic" of specific psychopathological disease categories (D. Smith, 2006a: 78). The ensuing production of medical and psychiatric "knowledge" through such discourses gives the appearance of objectivity and neutrality (Reuter, 2007: 21). However, medical knowledge is both a product, and a reflection of social forces, thus it both reproduces as well as reinforces dominant social ideologies (Wright & Treacher,

1982: 5). Medical professionals possess the authority to define social problems according to dominant ideologies and discourses and legitimate medical intervention into ever-increasing aspects of life, thus giving them enormous social control and regulatory power over individuals (Conrad, 1992: 224). While medicalization and pathologization lend power to medical authorities, social problems become decontextualized (Conrad, 1992: 224) and people are held individually responsible for their own health and well-being.

In *Institutional Ethnography as Practice* (2006a) Dorothy Smith provides an example of the ways in which pathologizing frames can be embedded into institutional texts. The process may involve three steps: an initial interpretation of behaviour as pathological, a description of the behaviour, and a “follow-up pathologizing interpretation that tells the reader to see the foregoing as symptomatic” (D. Smith, 2006a: 78). Texts offer “contextually isolated accounts of the subject’s behavior” so that the behavior is interpreted as symptomatic of some pathology (ibid.). As we will see, this process can be observed in several aspects of CSC’s women’s prison policy, rendering women inmates vulnerable to pathologization in a variety of ways.

As I have shown, CSC policy prioritizes security and management in the classification of prisoners, and tends to associate women’s past experience of marginalization first, with mental health needs, and finally with security risk. This renders many women inmates vulnerable to pathologization because of their high rate of past experiences of abuse. The rate at which women inmates are diagnosed with some form of mental illness while incarcerated, approximately one in four, is a significant indication of their vulnerability to pathologization (CSC, 2007a). As stated earlier, the ambiguity of CSC’s definition of “mental health” (or more accurately, its ambiguous

definition of behaviours warranting mental health interventions) facilitates the medicalization and pathologization of prisoners' behaviours. This is further evidenced in many of the therapies and strategies provided by CSC, including Dialectical Behavioural Therapy (DBT), Psychosocial Rehabilitation (PSR), the Intensive Healing Program (IHP), and the strategies used to "treat" Fetal Alcohol Spectrum Disorder (FASD) and transsexuality.

The Structured Living Environments have a "Coordinated Care Committee" much like the "Mental Health Interdisciplinary Team" outlined in the *2002 Mental Health Strategy*. The circumstances under which "trained" staff may refer women to the "Coordinated Care Committee" to be placed in the SLEs include:

A sudden and unanticipated change in behaviour that results in the woman's inability to participate meaningfully in her activities of daily living...An insidious changes [*sic*] in behaviour that over time results in the woman's inability to participate meaningfully in her activities of daily living... Individual behaviours (bizarre, intrusive, etc.) that make it virtually impossible for the woman to meaningfully integrate into the regular houses... On-going adjustment difficulties in a regular houses [*sic*] that requires a supportive environment (NIWG, 2002: n.p.).

These broad descriptions of behaviour allow regular prison staff to begin the process of medicalization, based on their own personal medical interpretations of the prisoners' behaviours. Again, such practices allow CSC's staff, whether they be medical/psychiatric professionals or not, to impose their own definition and interpretation of 'normal,' 'appropriate,' and 'adjusted' behaviour onto prisoners. The circumstances under which women are to be referred to the SLEs generally involve situations in which staff deem that prisoners are unable to "integrate" or "meaningfully...participate" in prison (NIWG, 2002). Such a prescription assumes that prisoners can easily adjust to incarceration, and blames them for their inability to function normally in a carceral environment. Yet, these

policies assure that women prisoners must acquiesce to institutional practices lest they be deemed mentally ill by staff, and moved into a more disciplined or 'structured' living environment.

Somewhat ironically, the *Structured Living Environment Operational Plan* acknowledges that women learn "deviant behaviour patterns" through institutionalization which undermine their successful return to the community (NIWG, 2002). One of the treatments offered to women in the SLEs, Psychosocial Rehabilitation, seeks to treat the very deviance learned through their incarceration and institutionalization (ibid). However, the *Structured Living Environment Operational Plan* defines deviant behaviours that warrant referral to the "Coordinated Care Committee" so broadly, that normal, everyday, common responses to incarceration increase the likelihood of medicalization. In an amazing circular logic then, the CSC acknowledges that women learn "deviant" behaviours that halt their "correction" while in 'Correctional Institutions,' while pathologizing and medicalizing such acts, thus justifying further "correctional" and "therapeutic" programming.

In much of its policies on therapies, CSC eschews the role of environmental factors in favour of an individualizing discourse which holds women responsible for perceived mental health problems. DBT is provided to women who are deemed to exhibit "emotional dysregulation," characterized as problematic behaviour associated with high sensitivity and extreme reactivity (NIWG, 2003: n.p.). CSC characterizes "problematic behaviour" which solicits the use of DBT, as having resulted from

- 1) deficits in important interpersonal, self-regulation and distress tolerance skills, and 2) personal and environmental factors that *reinforce maladaptive behaviours* and/or inhibit the use of existing behavioural

skills and the development of new skills and capacities (Fortin, 2004: 13, *italics mine*).

This ideological perspective is further elaborated in CSC's policy for the Intensive Healing Program (IHP), which is administered to women inmates institutionalized at the Regional Psychiatric Centre in Saskatoon. The stated goal of the therapy is "transforming the thoughts and behaviours *that often are the source* of the women's problems" (Laishes, 2002: 22, *italics mine*).

Such statements eschew social explanations for women's mental health problems and, instead, frame women's problems as emanating from the women themselves; from habitual thoughts and behaviours for which they are responsible, and must work to correct. Here, "maladaptive behaviours" are said to merely "reinforce" environmental factors, but do not *cause* "problematic behaviour," which is seen to arise only from pre-existent personal deficits and maladaptive tendencies which themselves have no apparent root cause. This statement provides a frame which allows CSC staff to interpret behaviours as rooted in the prisoners themselves, eschewing any sociological explanation for this behaviour. It also illustrates another technique in CSC's management model of incarceration, whereby "behaviours" are framed as "maladaptive" to what is assumingly an unproblematic incarceration, justifying the imposition of DBT, IHP, or some other therapeutic regime. The onus is thus placed on prisoners to adapt to incarceration, rather than the other way around.

DBT policy not only decontextualizes "problematic behaviors" by locating them as rooted in the individual rather than in social forces, it also pathologizes the fluctuation of emotional states by assuming some level of "normal," consistent, regulated emotionality to which incarcerated women inmates can be compared. Such a strategy

allows CSC staff to pathologize inmates' responses to incarceration that are not consistent with compliancy and acquiescence. As one of the express goals of DBT is to make prisoners "function effectively in an institutional setting" (Sly & Taylor, 2003: 3), CSC then admittedly provides therapies to prisoners in order to make them more easily manageable. In policies for both DBT and PSR, CSC states that the therapies are most effective when women inmates cooperate with their treatments (Sly & Taylor, 2003, 2005), thus placing the onus on prisoners to acquiesce to treatments, rather than tailoring treatments to the needs of prisoners. This condition indicates that these therapeutic regimes are used to facilitate institutional security and management (rather than genuine emotional healing) by pathologizing women inmates in order to apply institutional regimes. Again, CSC's mental health policy thus conflates what's best for the individual with what's best for the institution.

CSC policy also facilitates the medicalization and pathologization of women prisoners through the application of specified disease categories, such as FASD and "Gender Identity Disorder." Various categories of fetal alcohol-related disorders—Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE), or Fetal Alcohol Spectrum Disorder (FASD), which are considered to cause both physical and mental impairment—are addressed in several health policy documents for women inmates. Although the *2002 Mental Health Strategy for Women Offenders* admits that adequate diagnostic tools for FASD do not exist, it is asserted, nonetheless, that the prevalence is especially high in prisoners (Laishes, 2002: 36). Currently, there is an "educational campaign" regarding FASD within women's prisons which inconspicuously targets Aboriginal women as both "carriers" and "providers" of FASD (Pate, February 21, 2006). Although one's "race"

does not supposedly impact the damage caused by prenatal drinking, such representations construct Aboriginal women as potential ‘carriers’ of the disease, while white women are apparently treated as more exempt from such risk. The *Secure Unit Operational Plan* illuminates this bias when it states as fact that, “Among certain Canadian Aboriginal groups, the incidences of FAS/FAE is [*sic*] much higher” (NIWG, 2003) and cites one of its own publications as the source for this information.

Such an assertion exposes a racial bias within CSC health policy which assumes FASD to be predominantly an Aboriginal disorder as it fails to consider the social contexts within which such diagnoses are made. Elizabeth Armstrong argues that the development of FAS as a diagnostic category reflected a moral entrepreneurship on behalf of the medical establishment “who ‘recognized’ a new ‘syndrome’ and ascribed an etiology to it, with little definitive proof” (1998: 2025). From the outset, FAS diagnoses were disproportionately attributed to women of color and Aboriginal women, assuming alcohol to be the single ‘cause’ of particular characteristics. The role of wealth and its associated privileges (good nutrition, support services, education, etc.) were ignored as factors in women who consumed vast quantities of alcohol, yet whose children rarely exhibited signs of FAS (2028). The CSC acknowledges that today there remains no reliable method to diagnose FASD (Laishes, 2002: 36), and that its own diagnostic tools for the “syndrome” are unreliable (Laishes, 2002: 36). As such, the risk is especially high that such a label could be applied in discriminatory ways. For example, CSC’s own diagnostic definition of FASD is composed predominantly of sociological characteristics, some of which reflect socially-defined criteria of morally appropriate behavior, including:

Impulsivity...difficulty processing cause and effect, poor understanding of consequences, difficulty differentiating between right and wrong, poor adaptive functioning, poor sense of social boundaries...It also leads to frustration, intolerance, inappropriate sexual behaviour, substance abuse, mental health problems and trouble with the law (NIWG, 2003: n.p.).

Such a policy may initiate diagnoses of FASD upon women in particularly ambiguous situations according to what CSC staff consider inappropriate, immoral or unruly behaviour. It may be argued that it is simply more likely that Aboriginal women are *assumed* to be carriers of FASD by CSC staff, and the medical field at large, based on racist prejudice, and that these diagnoses are legitimated through ambiguous symptomology and diagnostic tools.

The management of transsexuals in prison provides another example of CSC's appeal to biomedical and psychiatric 'knowledge.' CSC policy regarding transsexuals is contained in the Commissioners Directive 800 (Coulter, 2008), which mandates the penal and medical treatment of transsexuals. Transsexuality is defined as a *de facto* psychiatric condition, "Gender Identity Disorder," necessitating a 'proper' diagnosis by an institutional psychiatrist. Inmates are permitted to maintain hormone replacement therapy only once they have been ascribed this psychiatric diagnosis. To obtain this diagnosis, however, the "disordered" person must be surveilled and evaluated by gender identity specialists (Namaste, 2006: 166). Only once sex-reassignment surgery has been completed may they be transferred to a gender-appropriate prison (Coulter, 2008). Transsexuals are thus subject to a nexus of surveillance, and medical and penal policy, which validates transexuality solely on the basis of psychiatric and bio-medical practice.

More recently, the CSC has begun to recognize some of the problems associated with pathologization. CSC's *Standards for Health Care* bans the use of medications for

control or disciplinary purposes for all inmates, both male and female (CSC, 1994: 24) (although such a policy is significant in that it is an implicit acknowledgement that such a practice is possible). CSC policy also frequently acknowledges the right of all prisoners to refuse treatments and the necessity of voluntary consent. The *2002 Mental Health Strategy for Women Offenders* mandates that programming must avoid labels, including those for psychiatric diagnoses, as they “may function to reduce women to only their mental health issues” (Laishes, 2002: 11). But more significant is the Strategy’s statement on the use of psychopathology diagnoses. It states

CSC does not support research on the issue of psychopathy in women offenders, regardless of how it is measured. This is, in part, due to the extremely low base rate of recidivism within the federally sentenced women's population and the virtual non-existence of violent recidivism ...Moreover, the assessment of psychopathy may impose divisive and diminutive stigma that contradict Principle 1 of the Strategy regarding wellness and the avoidance of labels. (Laishes, 2002: 21)

These policies are significant in that, in the least, they recognize that there are serious negative consequences of pathologization, and at the most, they appear mandate the CSC to take steps to avoid such consequences. While these policies are commendable, however, the CSC has largely failed to achieve many of these goals in practice. As we have seen, women prisoners are frequently denied the right to refuse treatments in prison, are exempt from involuntary consent, or are flatly coerced into certain treatment regimes. Although informed consent and the right to refuse treatment is repeated throughout CSC’s policy texts, it is clear that this is by no means a consistent standard for women inmates. The *Standards for Health Care* authorizes the use of involuntary treatment (CSC, 1994: 6), although CSC has failed to investigate or maintain statistics

about the frequency with which involuntary treatments are imposed upon prisoners¹¹. It is known in the case of DBT and PSR, however, that a full third of women reported feeling coerced into entering the SLEs to be provided these therapies (Sly & Taylor, 2005). Furthermore, while CSC may acknowledge the value in avoiding labels for women inmates, this does not necessarily speak to its everyday practice. At least 25% of women are given a psychiatric label as soon as they enter prison, and many more may be diagnosed throughout their incarceration. Such diagnoses will frequently result in the prescription of medications. And while CSC may theoretically ban the use of pharmaceuticals for disciplinary or control purposes, all use of pharmaceuticals serves a disciplinary and control function by managing and governing the conduct of individuals according to prescribed normative codes of behaviour. Clearly, women continue to be frequently labeled according to psychiatric diagnoses, and prescription pharmaceuticals are a common consequence of diagnoses. Even if CSC has instituted a policy against psychopathy diagnoses, the diagnosis is avoided primarily because women rarely re-offend, especially when it comes to violent recidivism (Laishes, 2002: 21). This policy speaks to the circumstantial nature of women's criminal acts; women's low rate of recidivism demonstrates their lack of 'intrinsic criminality.' The "virtual non-existence of violent recidivism" suggests that most incarcerated women do not possess criminal tendencies at all, but rather, are likely provoked into crime under particular conditions. If the CSC recognizes that women pose such a low risk for recidivism, it is unclear why CSC does not eschew other mental illness diagnoses it associates with criminal

¹¹ According to CSC National Pharmacist, Craig Shankar, in a personal email sent to me on March 18th, 2008.

behaviour, or why it refuses to relinquish more women into their communities to serve alternative sentences.

By assuming and prescribing a standard of emotional “normalcy,” and employing a broad definition of behaviours legitimating medical intervention, CSC allows itself to “cast a wide net” (Peters, 2003: 5) with which to pathologize prisoners. These therapies constitute “technologies of the self” (Foucault, 1988) as prisoners are expected to transform themselves in order to achieve their own “correction” and “rehabilitation.” Prisoners must become the doctors to themselves (Foucault, 1988: 31) by submitting to the knowledge of medical professionals as a “matter of their own freedom” (Rose, 1996: 58). On the one hand, these practices allow CSC to impose discipline and regulation upon women inmates as a means to achieve institutional order. On the other, CSC reinforces dominant cultural ideologies by appealing to biomedical disease categories such as with Gender Identity Disorder, FASD, and Borderline Personality Disorder. By enforcing these diagnoses upon women, which present an appearance of objectivity and neutrality, the racism, sexism, or heterosexism that inform their construction is made invisible, and the prisoner is held responsible for her own “treatment.” Similarly, the application of DBT, PSR and IHP serve to pathologize women’s emotional reactions to incarceration, while simultaneously responsabilizing them for the correction of emotional problems incurred from past experiences of distress. As women are responsabilized for their own correction and rehabilitation, attention is deflected from social forces that carve their path to conflicts with the law. CSC’s women’s health policies not only serve to produce subordinate institutionalized subjects, they negate the role of oppression in women’s conflict with the law and legitimize the social control of women at a broader level. Such

processes can be observed empirically by analyzing the concepts, discourses, prescriptions, definitions, and ideologies which are present in texts, and which shape the ways in which institutional action occurs.

Pathologizing Frames: A Textual Illustration

Texts are a significant part of institutions because they play a primary role in ‘moving’ people around from day to day. Not only do texts articulate institutional policy, they mediate nearly all aspects of everyday institutional practice. Parole board measures, segregation procedure, disciplinary charges, therapy, or transfers to different prisons are all initiated through texts, such as official notices, applications, or contracts that circulate between various institutional personnel and prisoners. CSC’s mental health services are likewise textually mediated at all levels, from small texts such as doctor’s prescriptions, to larger more definitional texts such as the Immediate Needs Assessment, which is completed upon entry into prison and largely determines the CSC’s subsequent psychiatric classification and treatment of the prisoner (Laishes, 2002: 20). Such texts exemplify the processes and social relations of institutions, that are embedded within the classification systems and frames made available within the texts (D. Smith, 2005: 191).

The pathologizing frames that permit CSC staff to interpret prisoners as “pathological” are built into texts, and will be illustrated by offering two examples of CSC texts that are used to activate local sites of pathologization in women’s prisons. These texts have been shaped by higher-order texts which regulate the concepts and discourses that will be present in the text. As I have shown, CSC policies may be situated within an intertextual hierarchy, where each text plays a regulatory role upon the level beneath it. The highest text in CSC’s mental health policy, *The Standards for Health*

Care (CSC, 1994), first set out CSC's definition of mental health and mental health services, authorizing CSC staff to pathologize inmates for violations of what is assumed to be acceptable conduct. Women's mental health services policy has been regulated by this text, and as we saw in the previous chapter, these policies authorize more specific instructions as to how staff will respond to women inmates and activate mental health regimes. Finally, women's mental health service policy provides the most precise concepts, prescriptions and rules to staff which will regulate the specific texts employed to institute mental health services. These policies, such as the Intensive Intervention Strategy (NIWG, 2002, 2003) are read and understood according to the institutional discourses developed in the texts that regulate them. They present the crystallization of the ruling regimes which structure CSC organization, and shape the activity of those within prisons to act in concert with the CSC's ideological goals by employing its institutional discourses. The policies outlining the Structured Living Environments (SLEs) and the Secure Units, where many of CSC's therapies are provided to women inmates, demonstrate the ways in which texts serve to accomplish and activate social life. The foundation of personhood—acts, moods, thoughts or behaviours—may be mediated through a textual process, facilitating classification based on the institution's preferred discourses so that prisoners may be processed through institutional procedures. Two such texts will be discussed below to illustrate this process.

Upon referral to the SLEs, women prisoners must have a *Structured Living Environment Intake Referral Form* completed in order to be transferred to the new facility (see appendix A) (NIWG, 2003: Appendix E). The first section of the form inquires about the "Reason for admission request," providing five possible categories for

the reason for which the prisoners will be transferred (Suicidal behaviour, adjustment problems, communication/life/daily living skills, mental health/symptom management/cognitive abilities, or externalization factors). This section provides the available frames to which the prisoner must appeal to be admitted to the SLE. These conditions, then, are framed as symptoms of some form of pathological functioning for which the prisoner requires a therapeutic regime. Both the prisoner/patient and CSC staff then come to interpret her condition as an expression of some pathology in order to activate her transfer. The form also inquires into her psychiatric diagnosis and her current psychiatric condition, which is qualified through available categories of “mood,” and “affect,” amongst other “psychiatric” conditions (ibid.). These categories permit CSC to evaluate her according to criteria of both “normal” and “appropriate” moods and affects, illustrating the regulatory power of the institutional discourse to prescribe codes of “normal” and “acceptable” behaviour. Importantly, the form inquires whether the prisoner/patient has consented to the treatment voluntarily, indicating that women may be transferred to the SLEs and provided treatments without their consent. The form then inquires as to her “motivation level,” assumingly referring to her motivation to participate in the SLEs and subsequent treatment options. This type of inquiry is better understood as it is connected to CSC policy for its emphasis that women take “responsibility” for their own health, as well as their “correction” and “healing,” and that treatments are more effective when women “cooperate” with the imposition of the regime. Failure to acquiesce may be noted in this form, framed as a prisoner’s lack of motivation to participate.

Once women have been accepted into the SLEs, they have access to “Quiet Rooms” in order to obtain space, tranquility, and isolation. Such a space is not merely accessible by walking down the hallway, however. Prisoners must first submit a *Therapeutic Quiet Room Accountability Sheet* (see Appendix B) which “must be completed each time a woman utilizes this treatment option” (NIWG, 2002: Appendix D). This text exemplifies how even the simplest act of movement and space are sanctioned through a psychiatric lens. The document first inquires what incident caused the need for space and quiet and whether it is part of the prisoner’s “Treatment Plan.” The subsequent section inquires about the “emotional state” of the prisoner, providing specific categories of possible moods (either “normal,” elated, depressed, irritable, sad, or labile), as well as whether she expresses anxiety (distress, feeling unsafe, or overwhelmed by external stimuli) (ibid.).

Once this form is completed, the prisoners’ moods, thoughts, behaviours, etc. become objectified as factual and symptomatic of some variety of psychiatric disturbance. Before a prisoner has even entered the SLEs, she is already deemed to be pathological, and all consequent acts, moods, thoughts, behaviours, and so forth, within the SLEs may be seen as an “expression of her imputed psychopathology” (D. Smith, 2006a: 79). All of her own accounts and claims may then be discounted on the grounds of her recognized ‘abnormality’ (ibid). These available categories provide an example of CSC’s production of pathologizing frames used to interpret women inmates through “contextually isolated accounts” (D. Smith, 2006a: 78) of their mental states and behaviours so that they may be ‘institutionally actionable’—in this case, transferred to the SLEs or provided access to “Quiet Rooms.” These texts then “activate” and

“coordinate sequences of action” (D. Smith, 2005: 181; D. Smith, 2006a: 66) by calculating, objectifying and categorizing individuals through institutional discourses (D. Smith, 2005) so that they be processed by the institution.

Conclusion

The findings in chapter four provided an account of the day-to-day, local map of CSC’s women’s prisons and mental health service procedures. Once this map was established, this chapter traced the connections between the local social forces of CSC to the “translocal” (D. Smith, 2006a: 65) or “extra local” forces (D. Smith, 2005: 35) which determine its structure, allowing the ruling relations which shape the practices of the CSC to be illuminated. The analysis found three significant institutional ideologies within CSC’s women’s prison policies—decontextualization, responsibilization, and pathologization—and each of these were contrasted with the language of empowerment and feminism found throughout CSC policy. The CSC has not only shifted its penological discourse from “punishment” to “correction,” it has also heavily adopted gender-specific discourses for women’s prison policy; specifically, woman-centeredness and cultural sensitivity, choice, and healing. This research contests the validity of the “empowerment” model CSC policy has proclaimed to achieve, and instead, exposes the underlying institutional ideologies of CSC policy which reinforce systemic processes of oppression. These ideologies are textually-mediated (D. Smith, 2005: 183), and compose the “ruling” power of the institution to govern the everyday activities of women in prison. CSC’s recent shift towards so-called “woman-centered” incarceration maintains its androcentric character, including programming through mental health services that serves to

responsibilize inmates for their actions without acknowledging the social contexts through which these actions occur. Despite references to “empowering” penal praxis in CSC policy texts, systematic discrimination against women and Aboriginals persists within the CSC. Rather than allowing women’s particular circumstances of social marginalization to inform prison policy to benefit women, my analysis shows that the CSC justifies more institutional control, surveillance, and discipline of women who have endured past experiences of abuse, racism, and mental health problems, while denying the role that such circumstances play in women’s conflict with the law. The CSC purports to “correct” the individual by holding her responsible for her compliance with institutional policy, however, if women either fail or refuse to comply with CSC’s management strategy, blame is placed upon them, rather than incarceration itself, and further institutional discipline is justified. CSC legitimizes this process by its relentless emphasis on the significance of choice and responsibility in women’s prisons. It implies that women inmates can only be corrected through empowerment, empowered through choice, and provided choices so long as they may be held responsible for them. According to CSC policy, failure to achieve this objective not only corroborates that they are “bad” criminals, but they are also ‘mad’ or ‘mentally ill.’

Chapter Six: Conclusion

By conducting an Institutional Ethnography, which seeks to reveal the ruling relations that determine and organize people's everyday life through institutional processes and practices, I have sought to provide an 'alternative' knowledge about women, crime and mental health problems, illuminating the ideologies governing women's penal settings. The institutional knowledge of the law, government, and psychiatry can be re-conceptualized to reveal a different interpretation of women's lives, one that acknowledges the role that poverty, victimization, racism, and other forms of oppression play in women's criminality and mental ill-health. Limiting this Institutional Ethnography to a textual analysis of Correctional Service of Canada's women's prison policy, I have 'interrogated' the facts and discourses present in CSC's institutional documents for the ways in which they organize the everyday life of the prison, mental health services, and the women inmates confined therein. It is an ideal approach precisely because the prison is a highly textually mediated world which reinforces the nexus of ruling relations that govern many marginalized women's lives.

This research is embedded within three theoretical frameworks which served to guide the analysis and methodology: Feminist criminology, sociology of medicine, and Institutional Ethnography. These frameworks provided both the theory and analytical thinking which determined the methodological direction of the research. The particular problematic I sought to investigate was informed by these theoretical backgrounds, and the selection of the data and research questions emerged in tandem as I began to uncover exactly what was the "problem" I sought to solve. This process began to evoke questions about the criminalization of women in Canada, women's incarceration, and the ways in

which mental health issues intersect with both of these processes. Research on women's criminality has revealed the links between women's socio-politico-economic contexts and their criminalization. Women's economic marginalization plays a key role in their path to criminal activity (Steffensmeier & Allan, 2004), and recent shifts in neo-liberal governmental policies disproportionately affect women, leading to greater conflicts with the law (Balfour, 2006; CAEFS, 2005). Moreover, violence against women and girls frequently results in survival strategies to flee the abuse which are later criminalized, such as pan-handling, or sex work (Chesney-Lind & Pasko, 2004). The Canadian Human Rights Commission has recognized that there is a serious problem regarding the rate of women in Canada's federal prisons who have endured systemic oppression. The CHRC concluded that, "Women's most common pathways to crime involve survival efforts that result from abuse, poverty, and substance abuse. Research suggests that all of these factors are interconnected" (CHRC, 2003: 71). Women have also been disproportionately affected by "de-institutionalization," which has resulted in greater numbers of those affected by mental illness to become unemployed, isolated, homeless, and incur substance use problems, all of which can result in criminalization (Peters, 2003; Timmermans & Gabe, 2002). It has been argued that incarceration has now become the *de facto* alternative to psychiatric institutionalization (Peters, 2003; CAEFS, 2005). Feminist criminology has illustrated that, once women find themselves in conflict with the law and are incarcerated, the contexts in which women commit crimes and endure mental distress are decontextualized in numerous ways in prisons (see CAEFS, 2002, 2005; Correctional-Investigator, 2004; Faith, 1993; Hannah-Moffat, 1999; Monture-Angus, 2002; Pollack, 2000a; Steffensmeier & Allan, 2004), and women inmates are held

individually responsible for their crime and mental well-being (CAEFS, 2005; Hannah-Moffat, 2000). Sociological explanations for women's crime and mental ill-health are negated and become decontextualized through ideological "knowledge" which holds them individually responsible for their conflicts with the law and psychological problems.

My theoretical frameworks illustrate that women, on the one hand, may be more likely to arrive in prison with mental distress or develop mental health problems while incarcerated, and on the other hand, that they are particularly vulnerable to being diagnosed with mental health problems in problematic ways. Health has played a significant role in prison policy since the genealogical discourse governing penal regimes shifted from "punishment" to "correction and rehabilitation." This discursive transition reflected a shift to neo-liberal penal ideology which strengthened the governmental potential of incarceration. Feminist criminologists have argued that mental health policy serves to both discipline and regulate women inmates, governing the everyday practices of those subject to health services (Kendall, 2000: 83, 86) for the sake of control and management (Faith, 1993: 234; Hannah-Moffat & Shaw, 2001: 51; Peters, 2003: 6). These analyses indicated that women's criminalization and mental distress must be explored as a method of social control and subjugation, whereby women's poverty, victimization, criminalization, and mental health become the location of punishment, and "correction." Research on gender, criminalization, and mental health illustrated that it was necessary to put power at the heart of the analysis—the role of social marginalization in criminality and mental ill-health must not be negated. By holding prisoners responsible for "correcting" their own criminological and mental issues, attention continues to be directed away from the source of social injustice—those circumstances which pave the

way towards criminal behaviour and mental ill-health—social, political and economic oppression.

While this research was useful for guiding the direction of my analysis and identifying the “problematic” I would investigate, none of the research I found scrutinized CSC policy specifically, or connected to the ways in which institutional texts mediate or activate (D. Smith, 2005; D. Smith, 2006a) social relations they had identified as problematic. Institutional Ethnography was an ideal methodology to explore these problems, because it allows the researcher to understand the connection between micro social institutional processes and macro social systems of power, and illustrate how such processes are shaped by texts. Institutional Ethnography directs the researcher to take up texts as the central object of analysis and attend to texts as the “entry points” (Campbell & Gregor, 2004: 81) into the investigation. CSC policy served as the points through which I chose to explore the problematic, because it explicitly mediates the structure and organization of CSC, determining its practices and articulating its goals (Campbell, 2003: 12; D. Smith, 2005: 10). The theoretical frames provoked questions that identified the problematic I came to explore: How can we understand the demographic of women behind bars? Why are women inmates disproportionately poor, Aboriginal, uneducated, or have such high rates of past experiences of violence? Why are so many women in prison identified as “mentally-ill”? In what ways do texts shape these situations, and through what ideological processes are texts themselves shaped? The research questions that had emerged queried how governing texts of the CSC organize the structure and organization of women’s federal prisons; how these texts determine the local structure of the prisons, and to what ideologies and discourses they appeal. Once I had identified the

“problematic” (Campbell & Gregor, 2004; D. Smith, 2005) to be investigated, the local structure of the CSC could be mapped through policy analysis, and subsequently linked to the broader ideological powers which shape it. The analysis sought to investigate how texts play a decisive role in generating institutional and medical facts and how such ‘knowledge’ informs the prison policy and health services administered within prisons. The authority of institutional knowledge goes unchallenged, and shapes the actions of individuals within prison settings by coordinating their actions to serve the goals of the institution and by directing them to capitulate to institutional practice. This knowledge is not value-free; it is informed and reinforced by ideologies and power relations which are obscured by the appearance of neutral and objective factuality. This analysis “interrogated” (Campbell, 2003: 6) the projection of institutional knowledge in order to produce an account of day-to-day institutional action.

My analysis began with the selection of twelve institutional texts, many of which were significant governing policies of CSC’s federal women’s prisons and mental health services. The texts composed over 800 pages of CSC’s institutional directives. The selection of data occurred in tandem with the theoretical thinking that arose during the literature review. Three levels of data were identified, and plotted on an “intertextual hierarchy” (D. Smith, 2005, 2006a) according to the regulatory function they serve. The highest-order texts identified were the broad governing legislation and regulations of the CSC, which are applied to both men’s and women’s prisons: the *Corrections and Conditional Release Act* (CSC, 1992a), and the *Corrections and Conditional Release Regulations* (CSC, 1992b). These policy texts play a significant role in determining the structure and activities of CSC, and regulate all lower-order texts by specifying the rules,

concepts and frames employed in CSC policy. All institutional policy must appeal to these documents, since they ascribe the primary mandate of CSC and detail the methods through which CSC must manage its prisons, including the ways prisoners must be treated. This level of data contained a number of aspects that, once mapped with other levels of data, indicated serious limitations as well as problematic policies within the CSC with respect to women inmates. Notably, the protection of society is stated as the paramount consideration of the CSC (CSC, 1992a: n.p.), thus indicating that the protection of prisoners themselves is a secondary consideration. Nonetheless, both the CCRA and CCRR contain numerous clauses suggesting that CSC is mandated to protect prisoners from certain forms of discrimination and maltreatment, and to ensure their well-being, including mandates regarding: least restrictive measures; strip-searches by “same-sex” staff; the option to release Aboriginal inmates into the custody of the community; the prohibition of discrimination against women, Aboriginal prisoners, and prisoners with disabilities and mental health problems; the necessity of voluntary informed consent to treatments; consultations with Aboriginal spiritual leaders and “appropriate” women’s groups in the development of programming; the guarantee of a safe and “healthful” carceral environment; and the limited conditions under which “disciplinary actions” may be used upon prisoners (CSC, 1992a, 1992b). These particular policies became more relevant once they were mapped in relation to other levels of data. The sense they make comes from the ways in which other levels of data are connected to and embedded within these policies. When it comes to women prisoners and Aboriginal women in particular, it is apparent that many of these protections may not be achieved for a variety of reasons. There exists an enormous amount of contradiction between the protections guaranteed by

CSC legislation and the specific policies mandated for women inmates. Moreover, this level of data also sets out the fundamental frames employed in subsequent CSC policy, that of ‘criminality’ and ‘correction.’ These policies establish the regulatory frame wherein all prisoners are understood fundamentally as “offenders” who require “correction,” regulating subsequent lower-order policy to responsabilize the individual for her activities and ignore the social explanations for the prisoner’s crime. What is relevant about this level of policy, then, is that the explicit prescriptions in the texts that mandate CSC to protect prisoners must be understood as rhetorical rather than practical. More important, though, is the ideological language that frames prisoners as criminals in need of correction. This analysis, however, illuminates another interpretation of prisoners; that women behind bars may be better understood not as ‘criminals,’ but as ‘criminalized.’

The next level of data on the intertextual hierarchy, CSC’s women’s federal prison policy, was then plotted on the map of CSC’s institutional action so that links could be made between the levels of data. It is within this level of data that the CSC has most frequently proclaimed that it has achieved a new level of “woman-centered” and “empowering” penology, purportedly based on the principles outlined in *Creating Choices* (TFFSW, 1990). Within these new policies, however, it is clear that there remains a great deal of discrimination, mistreatment, and violations of the CCRA and CCRR against women inmates, and Aboriginal women in particular. Women placed under the CSC’s *Intensive Intervention Strategy* (NIWG, 2002, 2003) are subject to numerous restrictions upon their personal and bodily freedoms, high levels of involuntary placement in segregation, and a lack of voluntary informed consent obtained for treatments, all of which suggest that such populations are exempt from many protections

articulated in CSC's governing regulations, although no such statement was ever explicitly found in CSC policies. Women placed in the Structured Living Environments face a number of problematic policies as well, including their exclusion from Mother-Child programs (NIWG, 2002: n.p.), and high levels of coercion by staff to enter the SLEs and be placed under the treatment regimes therein (Sly & Taylor, 2003: 10, 2005: i). And while the development of the Healing Lodge may be a sincere, albeit misguided, attempt by the CSC to expand "Aboriginal" carceral models, many Aboriginal women are ineligible to be placed there because of their Maximum Security classification. However, the Healing Lodge's greatest significance lies not in the consideration CSC has purportedly developed towards developing "culturally-sensitive" programming, but in CSC's *expansion* of programming and housing opportunities for Aboriginal women which obfuscate community custody as a viable option for this population. The discrepancies between CSC's purported "protective measures" of prisoners, articulated in the first level of data, and the findings in next level of data on women's prisons, are significant because they indicate that the CSC has not only failed to achieve these protective measures for women, but it has also failed to achieve an "empowering," "culturally-sensitive," or "woman-centered" carceral paradigm.

Many of the claims that CSC has achieved an alternative carceral paradigm for women were found in its policies on women's health services—the third level of data in the intertextual hierarchy. Once this level of data was added to the map of CSC policy, numerous problematic practices were found with regards to CSC's treatment of women inmates deemed "mentally ill." CSC's *Standards for Health Care* (CSC, 1994), which is applied to both men's and women's prisons, is particularly significant since it contains

the conditions under which “essential” mental health services are provided (CSC, 1994: 12), by offering a vague and list of symptoms which will elicit services, and which empowers all CSC staff to broadly interpret prisoners as mentally ill. The rate at which women are identified as being mentally ill in their intake into CSC prisons alone suggests two troubling conclusions: that woman with serious mental distress are being incarcerated at high levels and that women are particularly vulnerable to having their mental states cast as pathological conditions by the CSC.

Several CSC policy texts include clauses which mandate the CSC to take special precautions with prisoners considered mentally unstable (including the CCRA, CCRR, and the Standards for Health Care) (CSC, 1992a, 1992b, 1994), such as when security classification is determined, when prisoners are placed in segregation or isolation, or when treatments are prescribed for prisoners. Moreover, women’s mental health policies claim that they reflect the principles of female-empowerment outlined in *Creating Choices*. The findings indicate, however, that there are clear violations of the protections and principles purported to govern mental health service provision to women inmates, and those deemed mentally ill in particular, and that instead, the CSC employs excessive restriction, control and discipline onto this vulnerable population. Although the instances in which voluntary informed consent is not obtained and prisoners are committed to therapeutic environments against their will are not clarified in CSC policy, there are indications that such instances occur nonetheless. Moreover, women provided the Intensive Intervention Strategy—those who are deemed to have especially high mental health needs—are subject to numerous restrictions on their freedom and violations of their rights; a practice that clearly contradicts CSC’s mandate to consider the mental

well-being of prisoners in all decisions it makes, as stated in the CCRA (CSC, 1992a: n.p.). There is also little evidence that the CSC actually imposes “community release” options for inmates deemed mentally ill, despite that this strategy is a prominent component of the ‘Continuum of Care’ model of women’s mental health services (Laishes, 2002). These finding corroborate claims by several feminist criminologists and prisoner advocacy groups (CAEFS, 2002: n.p.; Hannah-Moffat, 1999, 2001; Peters, 2003: 5) that the CSC conflates “high-needs” with “high-risk” when it comes to mentally unstable women prisoners, and places them in strictly controlled environments which may be particularly damaging to their mental health. The rate at which prisoners reported that they were coerced into entering SLEs (roughly one third) also corroborates the Canadian Association of Elizabeth Fry Societies’ claim that women are not freely “choosing” to participate in mental health programming (CAEFS, 2005: 13), despite CSC’s emphasis on “choices” in its policy. Rather than “healing” and “correcting” women with mental health problems, as mandated by all aspects of CSC policy, my research indicates that CSC mental health practices may do more harm than good to women in prisons, particularly those with psychological problems who are most vulnerable to coercive and controlling environments.

Other serious problems were found with CSC’s women’s mental health services which illustrate the ways in which CSC’s production of knowledge subsumes “the actualities of people’s experience” through the imposition of regulatory frames (D. Smith, 2005: 199). The methods in which the CSC determines mental health status for women through their Intake Assessment Forms, and employs therapeutic programming using complex batteries assessments, illustrates the “standardized terms and procedures”

(1990b: 125) and “technologically refined sets of questions and ratings” (D. Smith, 2005: 191) employed by institutions to fit prisoners into pre-established categories so that they may be “institutionally actionable” (Smith, 2005: 187). These texts, such as the Structured Living Environment Intake Referral Form (see Appendix A), the Therapeutic Quiet Accountability Sheet (see Appendix B), and the assessment forms used in DBT and PSR therapies, contain “pathologizing interpretive frames” (D. Smith, 2006a: 78) by offering accounts of prisoners’ behaviour devoid of the contexts in which they occur, which allow behaviours to be interpreted as symptomatic of some pathology. These frames project an image of neutrality and factuality, and indicate the ruling relations and ideologies to which CSC appeals to produce institutional “knowledge.” These therapies also illustrate the regulatory power of the psy-sciences in how they direct prisoner/patients to achieve a state of emotional “normalcy” which serves the goals of the CSC. These findings indicate that the CSC employs specific therapeutic regimes for the purpose of managing prisoners rather than developing a genuinely therapeutic environment for women who have endured serious and traumatic hardships throughout their lives, lending support to the argument made by several feminist criminologists and prisoner advocates that CSC’s women’s mental health services are in fact antithetical to therapy and rehabilitation for those with psychological problems (CAEFS, 2002, 2005; Faith, 1993, 1995; Kendall, 2000: 90; Peters, 2003). However, these texts produce selective “facts” about the therapies which privilege the institutional perspective and subsume the voices of prisoners by providing a positive evaluation of therapies despite the marginalized, yet apparent, critiques articulated by women inmates.

Once the various levels of data were mapped, highlighting the problematic operations of women's prisons and mental health services, the analysis provided an account of the translocal social relations in which these operations are embedded. Three primary ideologies were identified in CSC policy: decontextualization, responsibilization, and pathologization. While it is clear that the CSC ascribes an unrealistic amount of responsibility to women for both their crime and mental health problems, it fails to provide them with any semblance of meaningful choice in their incarceration, miscarrying its 'Responsibility→ Choice→ Empowerment→ Correction' objective. Not only are women inmates further punished and pathologized for resisting institutional demands, they are also frequently coerced into psychiatric and therapeutic programming. Furthermore, CSC's ability to provide women with meaningful choice and responsibility in their lives more broadly outside of carceral environments is almost non-existent.

Rather than correcting and healing inmates, CSC pathologizes women inmates in a variety of ways. By prioritizing security and management over therapeutic and empowering practices, the CSC imposes a psychiatric model which holds women responsible for their mental ill health. CSC policy "activates" the pathologization of women by prescribing mental illness diagnoses onto women who fail or refuse to acquiesce to institutional governance. Women are frequently coerced into therapy and diagnosed with mental illnesses when they are not compliant with institutional regulation, in some cases with the express purpose of making inmates more manageable. CSC's application of specific psychiatric diagnoses for women inmates reflects the inherent ideological biases in their mental health services. The *de facto* pathologization of transsexuals through "Gender Identity Disorder," the discriminatory application of FASD

diagnoses onto Aboriginal women, and the frequency with which women are diagnosed with “Borderline Personality Disorder” when they are emotional, unruly or unmanageable, all speak to the inherent ruling relations which structure CSC’s mental health policies.

Health services in prison serve to classify, regulate, and treat women according to dominant discourses of the psy-sciences. Prison is already a particularly aggressive form of governmentality because it is highly mediated through moral institutional knowledge, and serves the most visible function of discipline in society. The legal institution, not the accused, determines what constitutes a ‘wrongful’ crime, who constitutes a criminal, and what form of punishment the crime ‘deserves.’ The justice system, the prison system, and the health system therein, become the “apparatuses of security” of governmentality (Foucault, 1991: 102); rehabilitation cannot be imposed so prisoners are held responsible for their own “correction.” (Kendall, 2000: 88). The ‘problem’ of mentally ill prisoners provides a pointed example of the ways in which social problems are individualized in penal regimes and declared to be manifestations of individuals’ psychological deficits, rather than symptoms of broad sociological problems.

These findings contribute to the growing body of research which has provided critiques of CSC’s women’s mental health policies. The Canadian Association of Elizabeth Fry Societies’ response to the *2002 Mental Health Strategy for Women Offenders* argues that CSC must do more to ensure that chemical restraints such as medication are not used to pacify women prisoners (CAEFS, 2002: n.p.). They also argue that the right to refuse treatments needs to be better clarified, since there continue to be incidents in which women are forcibly treated if they have refused psychiatric

intervention (ibid.). Canada's Correctional Investigator, Howard Sapers, who oversees CSC's policies and procedures and investigates inmates' complaints, has noted the tendency in CSC's women's prison policy to pathologize women inmates. In regards to CSC's security classification system, he states, "The current tool translates social disadvantage into pathologies. The system also designates a disproportionate number of women with significant mental health needs as Maximum Security" (Correctional-Investigator, 2004: n.p.). Yvonne Peters of The DisAbled Women's Action Network Canada reiterated this analysis, stating "The CSC tends to cast a wide net when identifying women with mental disabilities by equating social disadvantage with having a mental disability" (2003: 6). Women who have been diagnosed with mental disabilities are not only more likely to be labeled as having "disciplinary problems" and subjected to over-classification (Peters, 2003: 5), those who act-out are more likely to be diagnosed with a psychiatric disorder, Borderline Personality Disorder in particular (Hannah-Moffat, 2004b: 377), making them more vulnerable to over-classification. Equally disconcerting is CSC's insensitivity to the *adaptive* function of many women's behaviours that are deemed problematic, such as self-harm and mutilation. Research indicates that these behaviours are often developed as coping mechanisms to survive the pain associated with abusive experiences, and it is therefore inappropriate to provide therapy to women presenting such behaviours (CHRC, 2003: 39). Such critiques are useful for identifying problems with CSC's treatment of women inmates, however, few, if any of this research illustrates how these problems arise from CSC policy specifically, or how such situations are empirically observable through prescriptions contained in texts. The advantage of Institutional Ethnography is that it provides an empirical analysis

of institutional praxis by first mapping the local social relations that are facilitated by texts, then highlighting the translocal social forces which create the problem being investigated. Institutional Ethnography illustrates that institutional ideologies are “built in” to policy itself, and policy reform may not, in itself, transform the ideological practices which shape the procedures of CSC. Simply adopting a language of “empowerment” has clearly done little to alleviate systemic oppression faced by women either inside or outside of prisons. Rather, CSC’s adoption of feminist language has been used to undermine the empowerment of women prisoners by holding them individually responsible for their crime and “mental illness.” However, the presence of feminist language in policy projects an appearance of social justice which shields CSC from further criticism.

This research does not deny that incarcerated women have vast and serious mental health problems, nor is the severity of many incarcerated women’s psychological distress being challenged; it is this very reality which makes them particularly vulnerable in carceral environments. Rather, this research challenges how women’s psychological problems are explained, understood, and treated through CSC’s health services, and whether these practices are appropriate, accurate, or effective. Although the CSC has adopted a language of gender-sensitivity and an appearance of feminist-inspiration, it is clear that women’s mental health services and “correctional” policies presuppose ideologies contrary to feminism and social justice. Medical diagnoses are used to individualize and responsibilize subjects, subsuming social explanations and contexts for mental distress. The organization of the institution depends on unequal power relations between staff and prisoners, where health services are merely another area through which

power and control can be asserted. Instead of addressing and curing women's mental health problems, prison health services construct mental health and constitute inmates' subjectivity by reinforcing the very ideological relations that govern women's lives and lead to their mental distress.

Punitive and disempowering treatment of women inmates is at the core of CSC's institutional structure. Despite the reforms that CSC has undertaken in the name of feminism, women inmates continue to be locked up, segregated from their families and communities, and subjected to psychiatric regimes which do little to address the systemic oppression they face in society. Rather than fostering an increasingly rehabilitative environment for women, these reforms serve to legitimize and justify women's imprisonment as a viable option, and shield CSC from critical evaluation (Hannah-Moffat, 2004a: 203). Women prisoner advocates have rejected CSC's claim that it has achieved "woman-centered" or "culturally-sensitive" incarceration. They argue that genuine therapy and rehabilitation is not the fundamental objective of prisons, because "any state correctional institution colludes with the ideologies of penality, which contradict all notions of healing" (Faith, 1995: 81) rendering a truly "empowering" carceral experience impossible (Balfour, 2000, 2006; CAEFS, 2002, 2005; Faith, 1993, 1995; Hannah-Moffat, 1999, 2001, 2004a; Hannah-Moffat & Shaw, 2000, 2001; Kendall, 2002; Micucci & Monster, 2004; Monture-Angus, 2002; Peters, 2003; Pollack, 2000b). These academics and advocates argue that CSC's institutional practice is dehumanizing, humiliating, punitive, controlling, confining, disciplinary and disempowering, and therefore only exacerbates mental ill-health, rather than heals it.

Some feminist and Aboriginal scholars who have come to such conclusions have called for greater feminist and anti-racist reforms within CSC prisons (Balfour, 2000; Faith, 1995; Girshick, 2003; Kendall, 2000, 2002; Micucci & Monster, 2004, 2005; Monture-Angus, 2002). For example, some have argued that if CSC refuses to relinquish custody of Aboriginal inmates into their communities, then culturally relevant programming should be made available within institutions, and that the CSC would benefit from including otherwise excluded Aboriginal voices within policy and decision-making roles (Monture-Angus, 2002: 18). Others have suggested that the CSC document and disclose all relevant information pertaining to security classification, punishments, transfers (especially voluntary or emergency), segregation, and all other decisions which undermine women prisoners' "liberty interests" (CAEFS, 2005: 9). Meanwhile, Balfour (2000, 2006) and Pollack (2000) have called for the replacement of CSC's therapies with "alternative, anti-oppression approaches" which recognize "women's experiences of systemic, interpersonal, and structural oppressions" (Balfour, 2006: 744). It has also been suggested that measures that provide women with a sense of power and self-determination (Hannah-Moffat, 2004a: 301), such as "peer support, training that continues into the community, harm reduction measures and non-judgmental counseling" (CHRC, 2003: 39) would be more effective and empowering. While these calls suggest that CSC should make some types of feminist reforms to prison policy, such reforms may actually do little to undermine the systemic disempowerment of prisoners built into prison policy. This research indicates that, ultimately, policy reforms justify prison as the *de facto* 'solution' to women's criminalization, and fail to challenge the broader ideologies which lead to women's crime and mental ill-health. Such reforms serve to

strengthen the neo-liberal regime governing criminalized women's lives by projecting the image that incarceration is an acceptable method of justice because it holds the individual responsible for their activities. However, such an approach simply continues to deflect attention away from the social conditions to which women are subject, and which largely cause women to commit crimes to begin with. As such, prison reform actually does little to achieve feminist practices, since both feminist and Aboriginal philosophy envision an entirely different approach to justice altogether (Faith, 1995; Hannah-Moffat, 2004a).

While CSC's prison reforms seek to append 'feminist' knowledge to an inherently controlling and disempowering institution, feminists advocate the re-distribution of power at a broader level in connection with systemic and structural inequality (Hannah-Moffat, 2004a: 309). Many have argued that women can not be "corrected" or healed behind bars in any context, and must be transferred into the custody of their community; particularly Aboriginal women and women with mental health problems (Balfour, 2000: 101; Correctional-Investigator, 2004: n.p.; Peters, 2003: 20). The Canadian Association of Elizabeth Fry Societies (CAEFS), the DisAbled Women's Action Network (DAWN), and CSC's own Correctional Investigator, have all called for CSC to outsource therapy and counseling to community-based, public health service providers, or relinquish prisoners into the custody of community-based services (CAEFS, 2002; Correctional-Investigator, 2004; Peters, 2003). Community-based professionals are better suited to provide mental health services, they argue, because their primary interest is the health of prisoners, rather than security or punishment (CAEFS, 2002; Peters, 2003). As Mohawk activist, feminist, and prison-abolitionist Patricia Monture-Angus explains, "I had trouble with law school because law is the study of the oppression of my people... The Canadian

Justice system is a system that entrenches total colonization of relationships. Every oppression that Aboriginal people have survived was delivered by the legal system” (Quoted in Morris, 2000: 117). This research has led me to conclude that CSC’s attempts to institute so-called feminist or culturally-sensitive reforms may be a sincere attempt to address criticisms from prisoners, academics, activists and organizations; however, such reforms either fail to achieve the empowerment of inmates that such groups have called for, or, more worrisomely, deepen the very systems of subjugation that lead to women’s problems with the law and mental health status, and subsequent governance behind bars. CSC’s misguided attempt to institute feminist policy has resulted in deep contradictions within policy texts that, on the one hand, claim to recognize and address the socio-politico-economic contexts of women’s lives and, on the other, deny such contexts in order to hold women responsible for all aspects of their behaviour in the same breath. Appending feminist principles onto an inherently disempowering institutional body fails to transform the macro social forces that lead to women’s disempowerment to begin with. The abolition of prisons altogether, and the elimination of broader systems of oppression, is the paramount goal for many activists, academics and advocates for prisoners’ rights. This is perhaps the most radical, but most effective way to empower criminalized populations.

Given that the elimination of sexism, racism, classism, heterosexism, ableism, etc., is not a tangible goal in any immediate sense, there remain other systems of justice better suited for women, victims of crime, and society at large, which could facilitate the abolition of prisons. Retributive justice systems, such as the current penal paradigm, seek to punish offenders, without exploring who has been harmed or how they could be healed

(Morris, 2000: 4). Similarly, restorative justice fails to probe why and how things came to happen; in other words, the social causes of crime (*ibid.*). In contrast, transformative justice seeks to explore the fundamental causes behind a criminal act and has the offender, victim, and community convene to explore the causes, consequences, and solutions to crime. The process seeks to transform the offender, the community, and the victim. Transformative justice does not require numerous state professionals—police, judges, detectives, lawyers, etc—nor does it require millions of dollars for prisons. It can be performed in a home, a community center, or an office. Many victims of crime do not report it to the police, choosing instead to confront the perpetrator, who is usually known to them in order to find reconciliation, which illustrates that individuals often, unknowingly, participate in transformative justice as it may feel better suited to their sense of validation and redress. Transformative justice places power in the hands of victims, who are permitted to help decide what is needed to correct the harm done to them. Offenders become personally responsible to the victim, to their community, and to themselves, rather than to an impersonal institution composed of decision makers whom they may never even meet. Transformative justice is also a preventative measure; offenders must explore and explain their behaviour, often in front of family and community who they become responsible to and cared for by, and who too learn from the offender's mistakes. It illuminates the root cause of problems for all people involved, educating both the offender and community.

It may only be through such alternative means of justice that women will be protected from the subordinating conditions of the correctional system. Many women have been so deeply failed by Canada's current correctional policy that it is literally a

matter of life and death, like in the case of Ashley Smith. The current system defines discrimination as policy, control as healing, and punishment as empowerment. A truly empowering correctional system would not embody the very power relations that cause crime in the first place. Crimes against autonomy, labor, the environment, youth, public space, and communities could replace the preoccupation our legal system has with crimes against private property and drug use. Communities could be empowered to decide how criminals are sentenced. Social explanations for crime could be acknowledged, and social resources used to correct such problems instead of building prisons. Individuals could be offered avenues of empowerment and truly be held responsible for their actions. The legal system could be re-conceptualized so that subordinated populations are offered support, relief, and solutions through justice. Then, and perhaps only then, will women be healed and corrected through the "justice" system.